

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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U.S. DEPARTMENT OF AGRICULTURE

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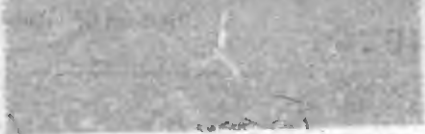
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00261												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												00257											
1. DECEASED NAME (Type or print) <b>Joseph m. Allender</b>												2a. DATE OF DEATH Jan Month 10 Day 69 Year												2b. HOUR 1:15 M											
3. SEX <b>male</b>				4. RACE <b>white</b>				5. DATE OF BIRTH <b>May 6-1884</b>				6. AGE (In years lost birthday) <b>84 YRS.</b>				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				IF UNDER 24 HRS HOURS MIN.															
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>BALTIMORE - Md.</b>																							
10. CITY OR TOWN OF DEATH <b>Towson 4 Md</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Towson Convalescent Home</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Ret. Farmer</b>				12b. KIND OF BUSINESS OR INDUSTRY																							
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md</b> COUNTY <b>BALTIMORE</b>				13c. CITY OR TOWN <b>Towson</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER <b>1658 Myamby</b>				13f. <b>1969 - Rd</b>																			
14. FATHER'S NAME First Middle Last <b>Nicholas Allender</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Clara Holland</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)												16b. SOCIAL SECURITY NO. <b>212-40-5986</b>				17. INFORMANT <b>Barbara Young</b> Address <b>Towson Conv. Home</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (this hospital) attended the deceased from <b>June 4, 1967</b> to <b>Jan 10, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan 10, 1969</b> , and that in (my) (our) opinion an death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE <b>Lawrence C. Post M.D.</b>												DEGREE <b>M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>1/13/69</b>															
22d. PHYSICIAN'S NAME (Type) <b>Lawrence Post M.D.</b>												22e. ADDRESS <b>6605 York Rd. Balto. Md.</b>																							
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Buried</b>				23b. DATE <b>1/14/69</b>				23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cem.</b>				23d. LOCATION (City or Town) (County) (State) <b>Long Green, Balto. Md.</b>																							
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>												ADDRESS				25a. DEATH BY REGISTRAR <b>JAN 14 1969</b>				25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>															

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UNITED STATES



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

00262

00258

1. DECEASED-NAME (Type or print) First Middle Last <b>CLARENCE F. ANDERSON</b>			2a. DATE OF DEATH Month Day Year <b>1/17 1969</b>		2b. HOUR <b>6:45aM</b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>10-9-1888</b>		6. AGE (In years last birthday) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore</b> Md.		
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto. Med. Center</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Salesman</b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>509 Walker Avenue 21212</b>	
14. FATHER'S NAME First Middle Last <b>Thomas Anderson</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Bettie Nelson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <b>unknown</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-34-3994</b>		17. INFORMANT Address <b>Mrs. Anna S. Anderson 509 Walker Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute bronchopneumonia</b> <b>582x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic renal disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular disease</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>1/15, 1969</b> , to <b>1/17, 1969</b> , that (I) (we) last saw the deceased alive on <b>1/17, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Charles C. Brown M.D.</b>			DEGREE <b>M.D.</b>	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>1/17/69</b>
22d. PHYSICIAN'S NAME (Type) <b>Charles C. Brown, M. D.</b>			22e. ADDRESS <b>Greater Baltimore Medical Center</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-20-1969</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Towson, Maryland</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Towson 1050 York Rd 21204</b>			25a. REC'D BY REGISTRAR DATE <b>JAN 20 1969</b>		25b. REC'D BY REGISTRAR <b>John J. Judge</b>

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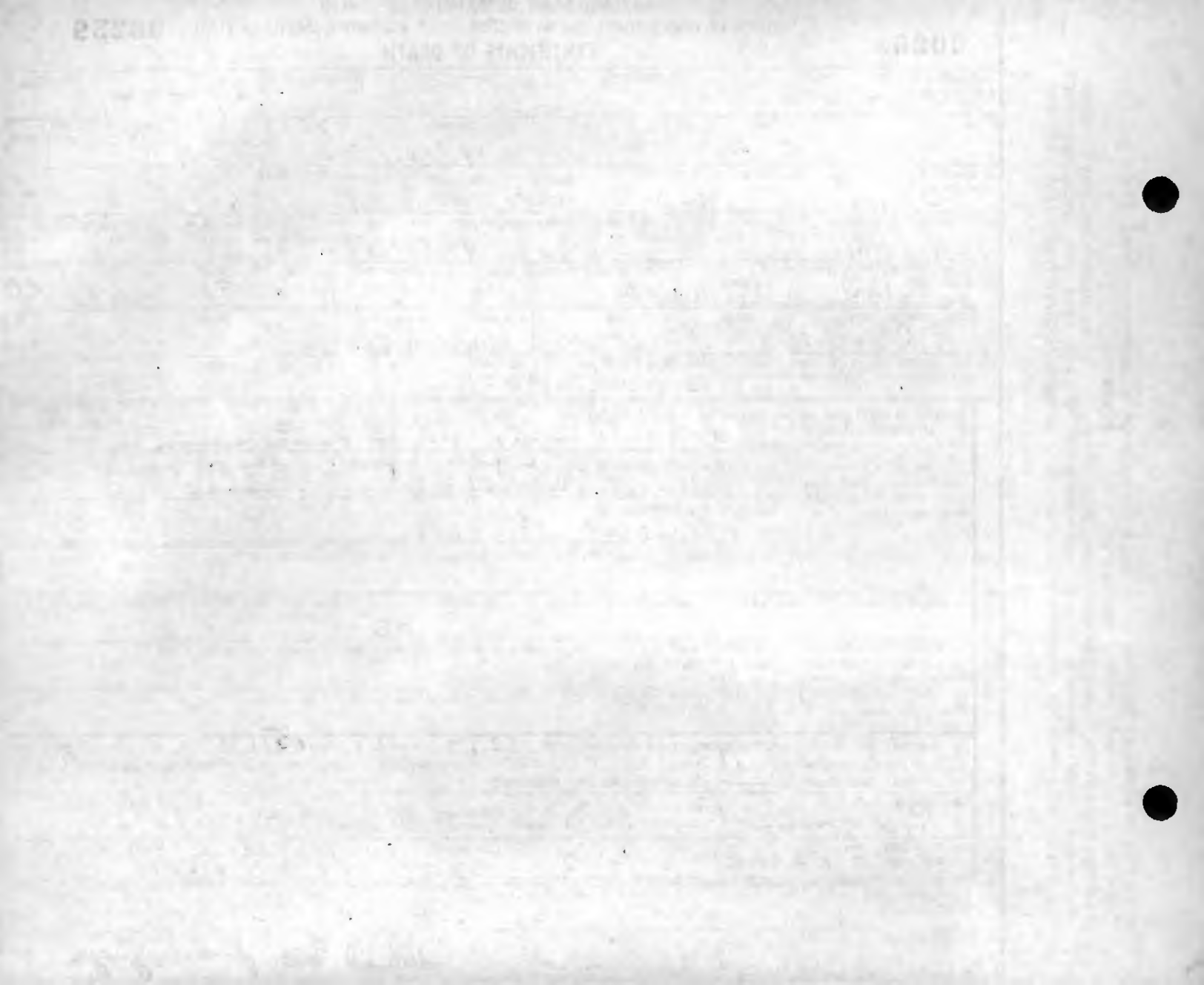
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00263 CERTIFICATE OF DEATH 00259											
1. DECEASED-NAME (Type or print) <u>ANDREWS - Regina</u>						2a. DATE OF DEATH Month <u>11</u> Day <u>5</u> Year <u>1969</u>			2b. HOUR M <u></u>		
3. SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>4/15/1886</u>		6. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS. HOURS <u></u> MIN <u></u>	
7a. BIRTHPLACE (State or foreign country) <u>BA Ho.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>BA Ho.</u>					
10. CITY OR TOWN OF DEATH <u>BA Ho.</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Summit</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>home maker</u>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>		13b. COUNTY <u>BA Ho.</u>		13c. CITY OR TOWN <u>BA Ho.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>4651 Briarcliff Rd</u>			
14. FATHER'S NAME First <u>Charles</u> Middle <u></u> Last <u>Doring</u>				15. MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u>Singer</u> Last <u></u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <u>no</u> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <u>214-22-6393</u>		17. INFORMANT <u>Mrs. Angelus Burnett</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERCALCEMIA possible parathyroidism</u> DUE TO, OR AS A CONSEQUENCE OF <u>due to parathyroid adenoma</u> (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral arteriosclerosis</u> (c) <u></u> 2520 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/4</u> , 19 <u>68</u> , to <u>11/5</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1/5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>E. Kasaiti M.D.</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>11/6/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>E. KASAITI'S M.D.</u>						22e. ADDRESS <u>1801 FREDERICK RD BALTIMORE MD 21221</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>1/8/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Co, MD</u>					
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks West Inc Balt. Md.</u>						25a. REC'D BY REGISTRAR DATE <u>JAN 10 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



00264

CERTIFICATE OF DEATH

00260

1. DECEASED-NAME (Type or print) <b>CHARLOTTE CASHMYER ANGEL</b>			2a. DATE OF DEATH Month <b>JANUARY</b> Day <b>15</b> Year <b>1969</b>			2b. HOUR <b>7:30 PM</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Dec 2, 1925</b>		6. AGE (In years last birthday) <b>43</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Catonsville</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>428 Montemar Dr.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>428 Montemar Dr.</b>							
14. FATHER'S NAME First <b>George A.</b> Middle <b>Cashmyer</b> Last			15. MOTHER'S MAIDEN NAME First <b>Marguerite</b> Middle <b>Fry</b> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>217-20-4685</b>		17. INFORMANT Address <b>John E. Angel 428 Montemar Drive</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Colon with General Metastases</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>1538</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/19</b> , 19 <b>33</b> , to <b>1/15</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1/15/69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Eliot W. Johnson M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/17/69</b>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>3432 Edmondson Ave. Baltimore Md 21229</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan 18, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Union Lut. Ch. Cent. Feezersburg, Carroll, Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Steele's Funeral Estate</b> <b>736 Edmondson Ave. Catonsville, Md. 21228</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 20 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Dr. John</i> <i>Angalone</i>					2a. DATE OF DEATH Month <i>1</i> - Day <i>22</i> - Year <i>1969</i>			2b. HOUR <i>6:30 P</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH		6. AGE (In years last birthday) <i>59</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Italy</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>			
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Joseph</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Dentist</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Dentistry</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>BALTO</i>		13c. CITY OR TOWN <i>Interpville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>503 Long Quarter Court</i>	
14. FATHER'S NAME <i>Salvatore</i> <i>Angalone</i>			15. MOTHER'S MAIDEN NAME <i>Josephine</i> <i>STRO</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213-38-8348</i>		17. INFORMANT <i>LORETTA I. ANGALONE</i>		Address <i>Same</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> <i>4123</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic cerebral artery disease</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1961-69</i> <i>1969</i> <i>1 year</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 28</i> , 19 <i>68</i> , to <i>January 22</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>January 22</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>E. J. Alessi</i> <i>M.D.</i>				DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <i>E. J. Alessi</i>				22e. ADDRESS <i>6217 Harford Rd</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>1-27-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>		23d. LOCATION (City or Town) <i>BALTO</i>		(County) (State) <i>Md</i>	
24. FUNERAL DIRECTOR <i>CHAS. T. EVANS</i>				ADDRESS <i>8802 Harford Rd</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 27 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Audrey A. Arnold						Month	Day	Year	11:40 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		F. UNDER 1 YEAR		IF UNDER 24 HRS	
F	W	2/16/09		59 YRS		MONTHS		DAYS	HOURS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Va.		U.S.				Baltimore			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonville		Summit & Pk. H.		Senior mach operator					
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before adm. ssion) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Anne Arundel		Baltimore				620-229st Street	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S M.A.DEN NAME			
Gordon						Della May Gibson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		
					216-16-4785		Mrs. Thelma A. Hartlove, 2512 Wilkens Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u>									1 WEEK
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>11/21, 1968</u> , to <u>1/30, 1969</u> , that (I) (we) last saw the deceased alive on <u>1/30, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (d.d. not) view the body after death.									
22b. SIGNATURE <u>S. Kerasi R. M.D.</u>					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/31/69</u>
22d. PHYSICIAN'S NAME (Type) <u>E. KASATIS, M.D.</u>					22e. ADDRESS <u>1801 Frederick Road, Baltimore 21228</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		2-3-1969		Glen Haven Cemetery		Glen Burnie, Anne Arundel Co. Md.			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Howard H. Hubbard, 4107 Wilkens Ave.					21229		PER 2 1000		<u>[Signature]</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) First Middle Last <b>David Grason Arnold</b>			2a. DATE OF DEATH 1 Month 22 Day 69 Year 11:05 M		
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>11/7/49</b>	6. AGE (In years last birthday) <b>19</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore</b> Md		
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto. Med. Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>211 Stanmore Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Stuart B. Arnold Jr.</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Edna Volz</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs. Edna V. Arnold 211 Stanmore Rd. #21212</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Medulloblastoma of the brain</b> <b>11/11</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter: nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> , 19 <b>69</b> , to <b>1/22</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/22</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Rudiger Breiteneker</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>January 23, 1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>		22e. ADDRESS <b>6701 N. Charles Street.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>1/27/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Mitchell - Wedepfel</b>		ADDRESS <b>6500 York Road</b>		25a. REGISTRY <b>JAN 27 1969</b>	25b. REGISTRY SIGNATURE



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VR 151  
45M 1-69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00263

00264

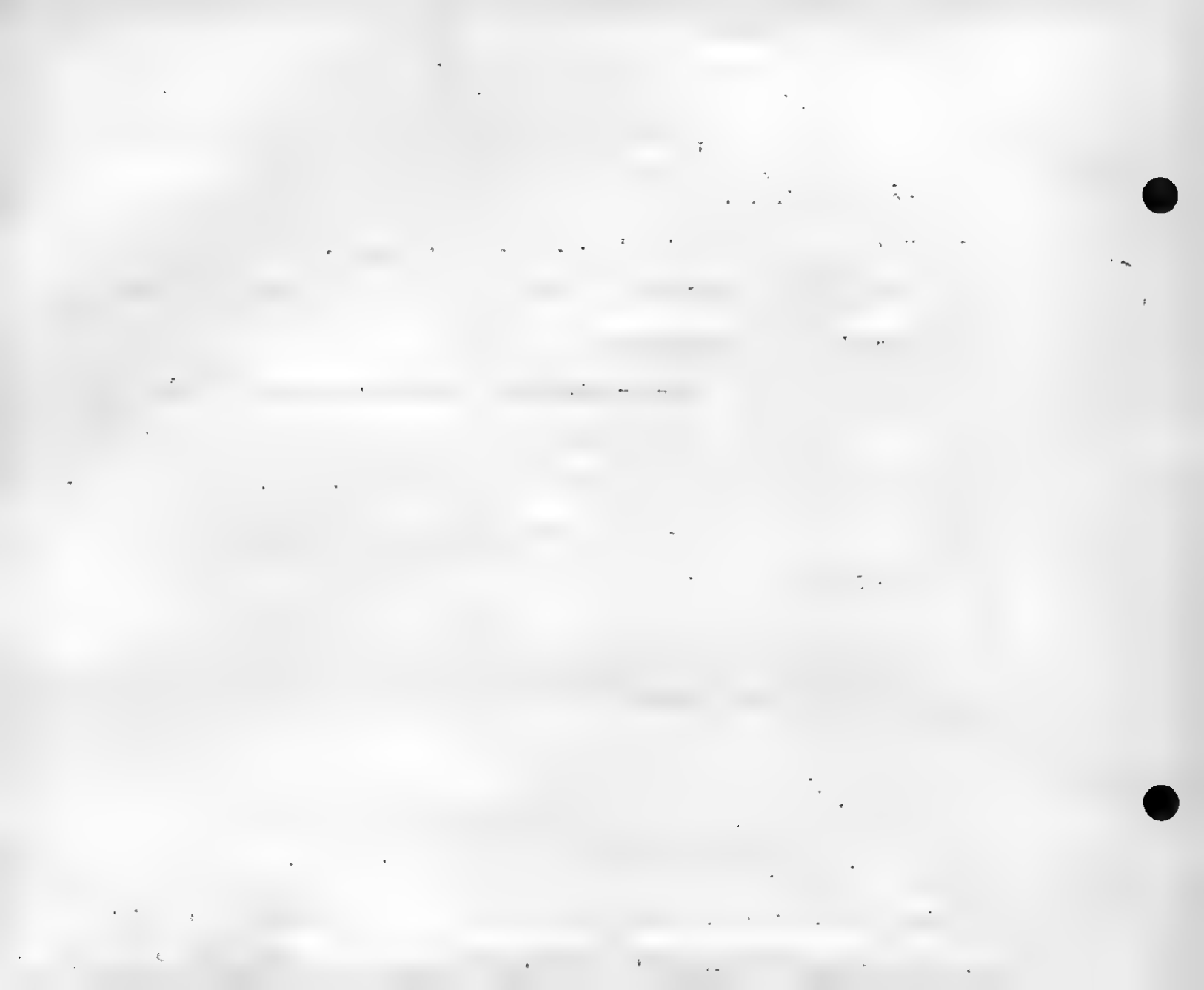
1. DECEASED NAME (Type or print)		First	Middle	Last	2c. DATE OF DEATH Month Day Year		2b. HOUR 8:45 P.	
Corinne		Auer			January 23, 1969			
3 SEX	female	4. RACE	white		5. DATE OF BIRTH	Sept. 28, 1888		6. AGE (In years last birthday)
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Md.		U. S. A.		Baltimore		Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville		SPRING GROVE STATE HOSP.		housewife				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY L.M. IS?	13e. STREET AND NUMBER			
Md.			Balto.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1805 Wilkens Avenue			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
		Buckheit						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
(If yes give war or dates of service)		216-03-8521		Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure								
4124 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) Arteriosclerotic cardiovascular disease								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
Diabetes mellitus								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from Nov. 11, 1968, to Jan. 23, 1969, that (X) (we) last saw the deceased alive on Jan. 23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		
Diomidis Pirovolidis, M.D.		1-23-69		Diomidis Pirovolidis, M.D.		Baltimore, Maryland 21228		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		1/27/69	New Cathedral Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Witzke, 4101 Edmondson Ave., 21229				DATE JAN 24 1969		R Charles Judge		



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR	
ROBERT J AUGUSTINE						1 Month 14 Day 69 Year		8:10 P M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 IF UNDER YEAR MONTHS DAYS	
MALE		CAU		10-22-84		84 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Wisconsin		U.S.A.				BALTIMORE Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
BALTIMORE			GREAT. BALT. MED. CENT.			Lumber		Lumber	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Baltimore			Timonium		13e STREET AND NUMBER	
								12 Gerard Avenue	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Robert Augustine Clara						??			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT Address			
No			217-05-1580A			Marie Augustine, Same as # 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u>								48 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBROVASCULAR ACCIDENT-THROMBOSIS</u>								7 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROSIS</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
<u>CONGESTIVE HEART FAILURE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-7-</u> , 19 <u>69</u> , to <u>1-14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>[Signature]</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c DATE SIGNED <u>1-14-69</u>			
22d PHYSICIAN'S NAME (Type) <u>EDMUNDO LABRANAGA, M.D.</u>						22e ADDRESS <u>6701 N CHARLES ST BALT, MD</u>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		1-18-1969		Dulaney Valley		Cockeysville, Maryland			
24 FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. Cook-Brooks Towson, 1050 York Rd. 21204						DATE <u>JAN 17 1969</u>		<u>[Signature]</u>	



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VR 4-5-64  
304M REV. 1-68

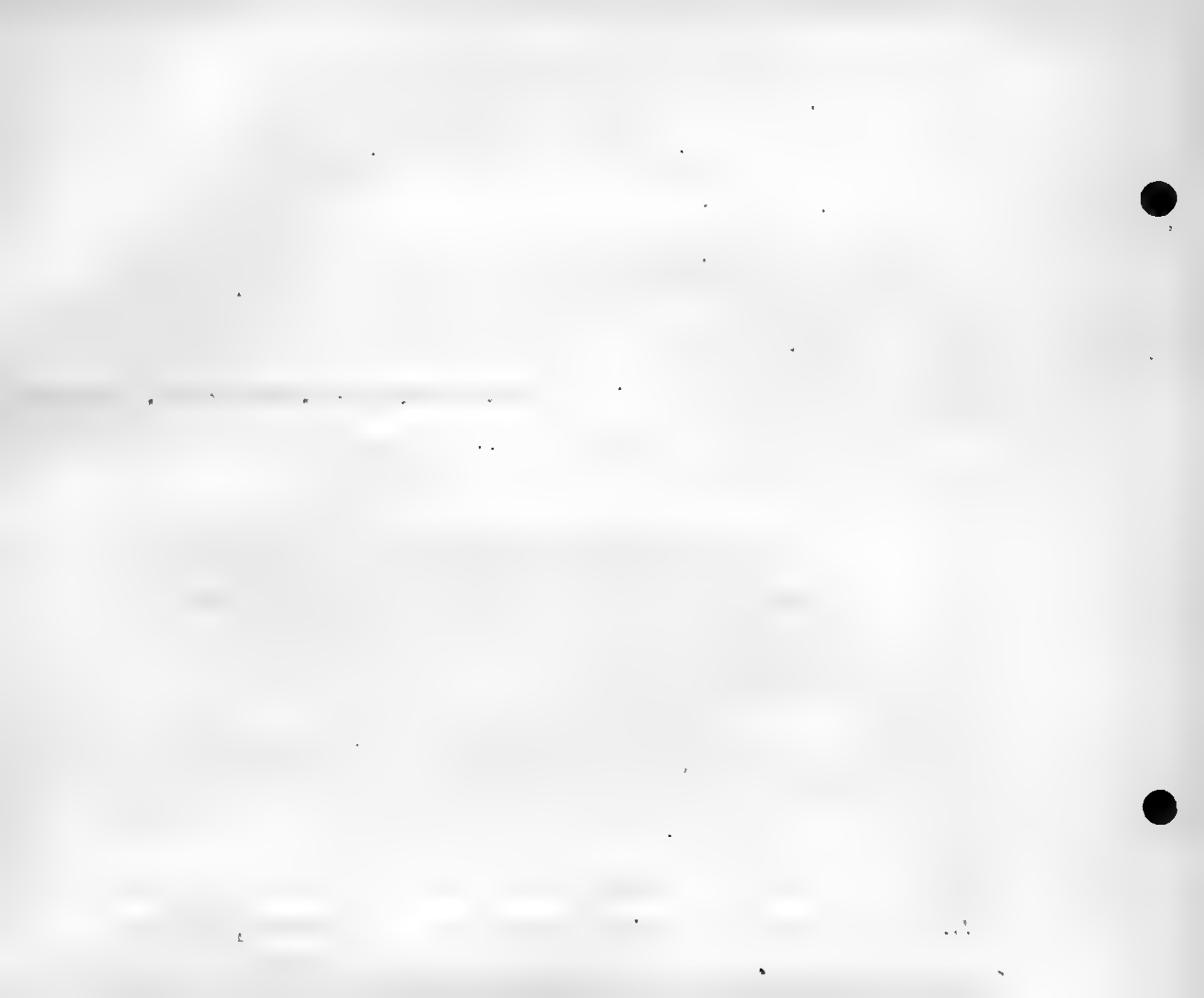
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00210		CERTIFICATE OF DEATH						00266			
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Sara		Elizabeth		Back		01		Month 06 Day 69 Year		M	
3 SEX		4 RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		3-28-92				76 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Balto. Md.		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Randallstown		Baltimore Co Gen Hosp.				housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TSP		13e. STREET AND NUMBER			
Md.		Baltimore		Balto		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7501 Digby Road			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
N/A		John		Ward		deceased		N/A			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
no				Mrs. Dolores Rosier		7501 Digby Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, DICHTERIAL</u>											
400X DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21d. N.L.R.Y. OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
C. Lee. goetz		1-6-69				CARL M. ORBEGGIO					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		1/9/69		New Cathedral Cemetery		Baltimore, Maryland					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Witzke, 4101 Edmondson Ave., 21229						DATE JAN 8 1969		J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print) First Middle Last <b>JOHN E. BAILEY Jr.</b>						2a. DATE OF DEATH Month Day Year <b>01 19 1969</b>			2b. HOUR <b>7:13 PM</b>			
3 SEX <b>Male</b>		4 RACE <b>Cauc</b>		5. DATE OF BIRTH <b>1904 03-07-1905</b>			6. AGE (In years last birthday) <b>64 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Cecil Co., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore Co Md</b>					
10. CITY OR TOWN OF DEATH <b>Maryland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GBMC</b>			12a. USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired) <b>Survey Tech</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Balto</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <b>18 E. Poultney St.</b>				
14. FATHER'S NAME First Middle Last <b>John Emory Bailey Sr.</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Price Rachel Jane Price</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO <b>217 16 0971</b>		17. INFORMANT Address <b>Rachel Bailey 18 E. Poultney St. Baltimore</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Development of Multiple Metastatic Lesions right chest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION <b>6-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>1-14</b> , 19 <b>69</b> , to <b>1-19</b> , 19 <b>69</b> , that (I) (we) lost the deceased alive on <b>1-19-69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Richard L. Lerner</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1-19-69</b>				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS								
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1/23/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MARYLAND</b>					
24. FUNERAL DIRECTOR <b>McCully 130 E. Fort Ave. Baltimore Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 20 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>						



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>Philemon P. Bailey</b>		2a. DATE OF DEATH Month <b>1</b> , Day <b>1969</b> , Year <b>1969</b>		2b. HOUR <b>9:30 AM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>December 5, 1902.</b>	6. AGE (in years last birthday) <b>66</b> YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore, Md</b>	
10. CITY OR TOWN OF DEATH <b>Parkville</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7417 Old Harford Road</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired—Gas &amp; Electric Co.</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>7417 Old Harford Road</b>
14. FATHER'S NAME First <b>John E.</b> Middle <b>Bailey</b> Last <b>Bailey</b>	15. MOTHER'S MAIDEN NAME First <b>Martha</b> Middle <b>Bartlett</b> Last <b>Bartlett</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16b. SOCIAL SECURITY NO. <b>212-05-4004A</b>	17. INFORMANT Address <b>Mrs. Eva M. Bailey (Same)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG WITH METASTASES</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>163</b>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 16, 1968</b> , to <b>Jan 1, 1969</b> , that (I) (we) lost saw the deceased alive on <b>Dec 23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Larry E. Tilley MD</b>	DEGREE <b>MD</b>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>1-2-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>L. E. Tilley, M.D.</b>	22e. ADDRESS <b>1713 Taylor Avenue 21231</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/4/69.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>JAN 2 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
J. Phillip Barber						Jan. Month 4 Day 69 Year		7:35 PM	
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
M		Cauc.		July 5, 1884		87 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md.	
Balto. Md.		U.S.A.				Balto.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
White Hall			Gibson Rd.			Icebox Supervisor		Dairy, Food Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto			YES		Gibson Rd.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Zebulon Barbour			Delilah Barbour						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			
No			216-10-8627			Mrs. Marie E. Barber, Gibson Rd. White Hall, Md. 21161			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebral Hemorrhage									
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral aneurysm									
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			Hour A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION			
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 19 43 to Jan 19 49, that (I) (we) last saw the deceased alive on Jan 19 49 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
Reginald B. Gemmill, M.D.			6 Jan. 19 49						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
Reginald B. Gemmill			Stewartstown, Penna.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			1/7/69			Hiss Methodist Cem			Balto. Md.
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
James S. Vartenstein, New Freedom, Pa.			JAN 10 1969			Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year	
Minnie							BARNHART		1 16 1969	
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years lost birthday)		7 UNDER 1 YR. MONTHS DAYS	
Female		White		August 12, 1893			75 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Baltimore, Md				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson		St. Joseph Hospital			Homemaker					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland				Baltimore				5014 Belair Rd.		
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME First Middle Last	
Harry H. Callsen									Catherine Schafer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT Address				
No			213-48-5868			James C. Busick, 1605 Wadsworth Way				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive pulmonary thrombo embolism</b>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost.										
(b) <b>cerebral arteriosclerosis</b>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>12/22/</u> 19 <u>68</u> , to <u>1/16/</u> 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>1/16/</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED	
									1/16/69	
22d PHYSICIAN'S NAME (Type)					22e ADDRESS					
Lawrence F. Misanik, M.D.					7620 York Rd., Towson, Md. 21204					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial		1-20-69		Parkwood			Balto., Md.			
24. FUNERAL DIRECTOR ADDRESS					25a RECEIVED BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc., 5305 Harford Rd.					DATE					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with forms 1, 2, and 3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

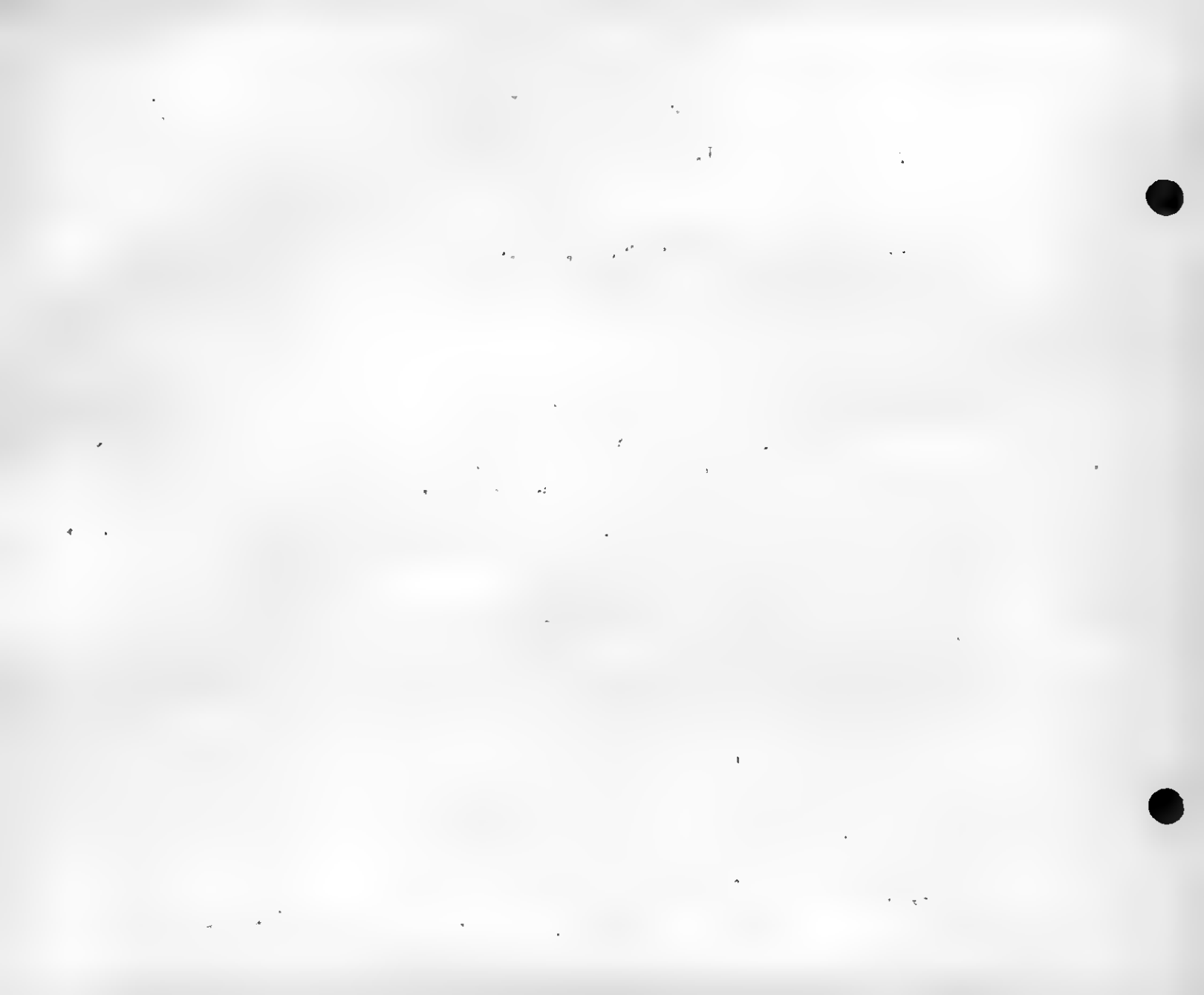
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> 1-9 1969		2b. HOUR M	
JOHN JOSEPH BAUMAN									
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years or birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR M	
Male	White	2/3/48	20 YRS			January 9, 1969		3:35 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U. S. A.				BALTIMORE Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
			Annapolis Road at New York Avenue			set up man		Westinghouse	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER		
Md.					Baltimore		1421 Cooksie Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William Bauman			Betty Murray						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
NO			219-52-3750		Mrs. Betty Preston 1421 Cooksie ST.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Multiple injuries									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			1:59 AM 1-9-1968		Driver in auto-auto collision				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCAT ON Street or R.F.D. No.		City or Town		County	State
		street		Annapolis Rd. at New York Avenue		Baltimore		Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			Charles S. Springate M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)			Charles S. Springate, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		January 9, 1969	
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCAT ON (City or Town) (County) (State)		
Burial			1/13/69		London Park Cemetery		Baltimore, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Charles S. Springate Funeral Home Inc.			1501 East Fort Ave.			JAN 14 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00270		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		00272	
Item 13 Film G409 2/13/69 kk					
1. DECEASED-NAME (Type or print) First Middle Last <b>JESSE NMN BEALL</b>			2a. DATE OF DEATH 1 Month 26 Day 69 <sup>or</sup>		2b. HOUR 11:50 <sup>P</sup>
3. SEX <b>MALE</b>	4. RACE <b>CAU.</b>	5. DATE OF BIRTH 2/8/07		6. AGE (In years last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE</b> Md.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT. BALTO. MED. CENT.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>2623 Greenmount Ave. 21218</b>
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF <b>Cancer of maxillary sinus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>1 mos.</b> <b>2 days</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>1/22/69</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA. OF MAXILLARY SINUS</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-11</b> , 19 <b>69</b> , to <b>1-26</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-26</b> , 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>WILLIAM A. ALONSO</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-29-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>WILLIAM A. ALONSO</b>		22e. ADDRESS			
23a. BURIAL (or CREMATION) REMOVAL (Specify)		23b. DATE <b>1-31-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wm. Med. School</b>	
24. FUNERAL DIRECTOR <b>Wm. Med. School</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 3 1969</b>	
25b. REGISTRAR'S SIGNATURE <b>Wm. Med. School</b>					



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <b>Henrietta</b>			First Middle Last			2a DATE OF DEATH Month <b>I</b> Day <b>4</b> Year <b>1969</b>		2b HOUR <b>4:30</b>	
3 SEX <b>F</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>7-18-04</b>		6 AGE (In years lost birthday) <b>1964</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Mont. Co.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>			
10 CITY OR TOWN OF DEATH <b>OWINGS MILLS</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rosewood State Hosp.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Germantown, Md</b>		13b COUNTY <b>Mont. Co</b>		13c CITY OR TOWN <b>GERMANTOWN</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
14 FATHER'S NAME <b>Charles</b>			First Middle Last			15 MOTHER'S MAIDEN NAME <b>Florence Ida Hurst</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT <b>Address</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Branchio C. obstruction, Necrosis,</b>									
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Neutering Branchio C. obstruction</b>									
DUE TO, OR AS A CONSEQUENCE OF (c) <b>24 Wks</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>instilled cannulized 57 yrs. Encephalopathy due to birth injury</b>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. B.T.N.G. <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR AM. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>3-12-17</b> , 19 <b>67</b> , to <b>1-4</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>4 Jan</b> 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Dr. Richard A. Jones</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>4 Jan 69</b>			
22d PHYSICIAN'S NAME (Type) <b>Richard A. Jones</b>				22e ADDRESS <b>Rosewood State Hospital</b>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <b>1/4/69</b>		23c NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>(Owings Mills, Md.)</b>			
24 FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons Reisterstown, Md.</b>				ADDRESS		25a REC'D BY REGISTRAR <b>JAN 9 1969</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First Viola			Middle Mae			Last Beard		
3. SEX female			4. RACE white			5. DATE OF BIRTH June 18, 1876			2a. DATE OF DEATH Month Day Year January 17, 1969		
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? U. S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Catoonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Whiteford			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME Samuel Orr			15. MOTHER'S MAIDEN NAME Sarah Henry			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 219-54-3022J1		
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4107 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic cardiovascular disease (b) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis, generalized (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 4, 1963, to Jan. 17, 1969, that (I) (we) last saw the deceased alive on Jan. 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Anthony J. Young, M.D.			22c. DATE SIGNED 1-17-69			22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.			22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE Jan. 20, 1969			23c. NAME OF CEMETERY OR CREMATORY Tabernacle Cemetery			23d. LOCATION (City or Town) (County) (State) Whiteford, Harford, Md		
24. FUNERAL DIRECTOR John H. Harkins			ADDRESS Delta, Pa.			25a. REC'D BY REGISTRAR DATE JAN 21 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10275

00275

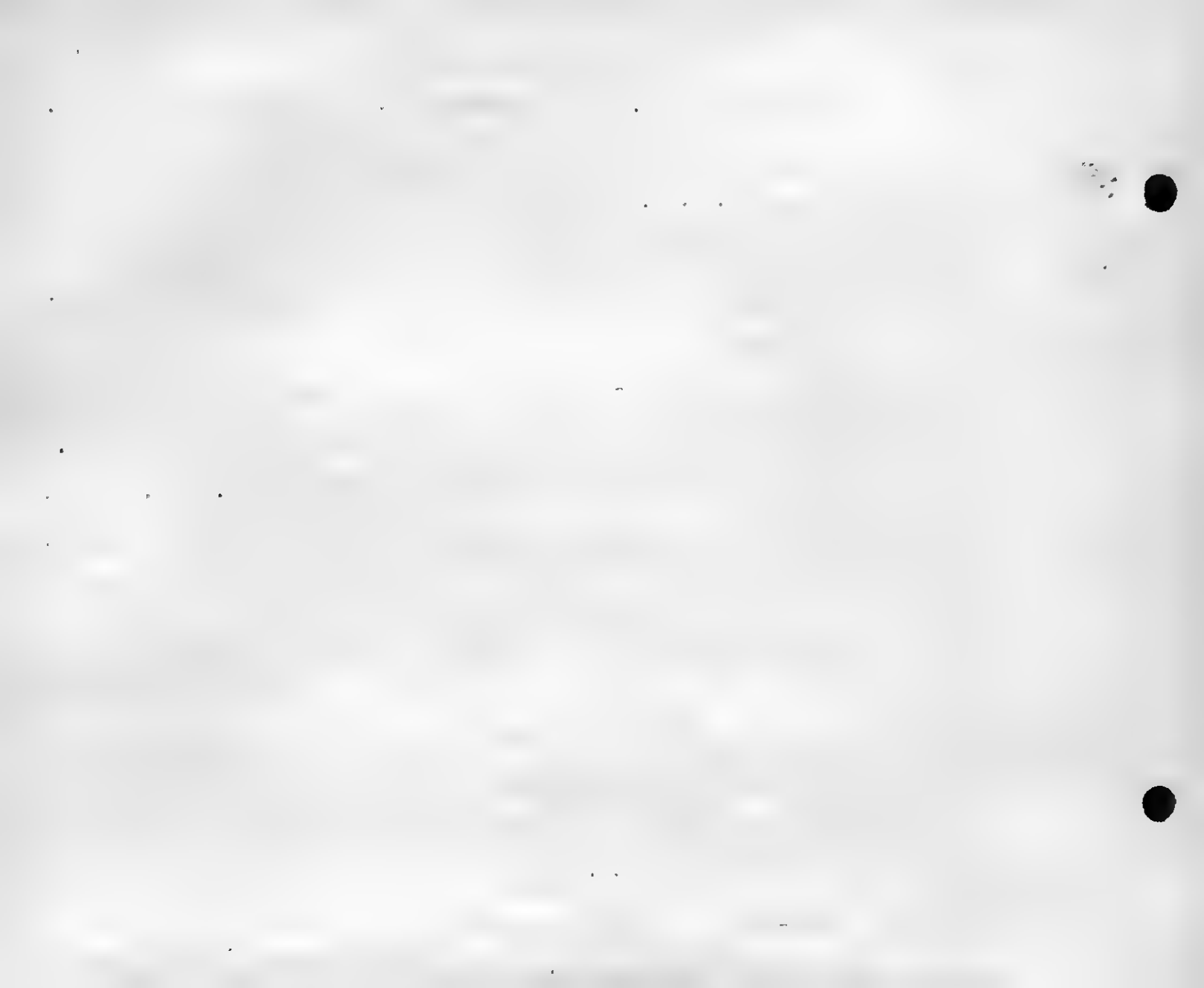
1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR		
Robert		John	Beecroft		Jan. 29 <sup>th</sup> 1969		Year 3 P.M.		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		
Male	White		June 14, 1888		80 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Pa.	USA				Balto. Co.		Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Boring		Rd.		Male Nurse		Hospt.			
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Md.		Balto.		Boring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RD	
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last					
John Beecroft				Lydia Kepner					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address					
		187-03-5314		Mrs. Thelma Sweisford Boring, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF <u>Arterio-sclerotic C.V. Disease</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10420</u> (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 22, 1968</u> to <u>Jan. 29, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan. 8, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b SIGNATURE <u>M.C. Porterfield</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>1-31-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>				22e. ADDRESS <u>HAMPSTEAD, Md</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Feb. 1, 1969		Mt. View Cemetery		Hazelton, Pa.			
24 FUNERAL DIRECTOR ADDRESS				25a RECEIVED BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE			
Tipton - Eline Funeral Home Hampstead, Md.				FEB 3 1969					



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1 DECEASED NAME (Type or print)		First	Middle	Last	Behn		2a DATE OF DEATH Month Day Year		2b HOUR
William		H.	Behn (Also Henry W.)	January 27, 1969		3:15 a.		M	
3 SEX	male		4 RACE	white		5 DATE OF BIRTH		6 AGE (In years last birthday)	
June 20, 1887		81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (State or foreign country)	Germany		7b CITIZEN OF WHAT COUNTRY?	U. S. A.		B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Baltimore								Md.	
10 CITY OR TOWN OF DEATH	Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
SPRING GROVE STATE HOSP.		plumber							
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		Md.		13b COUNTY		13c CITY OR TOWN		13d INS DE CITY, MTS?	
Balto.		YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		1937 West Lombard St.			
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
Henry Behn		Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
No		215-10-0453		Records: SPRING GROVE STATE HOSPITAL					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction, acute, with pul-								6 hrs.	
4109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic, Cardiovascular Ht. Dis.								3 yrs.	
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Arteriosclerosis, Generalized, Senile.								3 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
(a) Mitral Insufficiency, (b) Pernicious Anemia, treated, improved.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1b)					
		HOUR A.M. Month Day Year P.M.							
21d INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from Feb. 19, 1968, to Jan. 27, 1969, that (we) last saw the deceased alive on Jan. 27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c. DATE SIGNED		22d PHYSICIAN'S NAME (Type)					
Anthony J. Young, M.D.		1-27-69		22e ADDRESS					
				SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		1-28-1969		Meadowridge Cemetery		Howard County, Maryland			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REG. STRAR		25b REG. STRAR'S SIGNATURE			
Howard H. Hubbard, 4107 Wilkens Ave. 21229				DATE JAN 29 1969		J. Charles Judge			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

0028

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00277

1 DECEASED NAME (Type or Print) <b>George L. Behrends</b>			2a DATE KNOWN OF DEATH ESTIMATED <b>January 25 1969</b>			2b HOUR <b>12:15 PM</b>		
3 SEX <b>M</b>	4 RACE <b>W</b>	5 DATE OF BIRTH <b>4-30-16</b>	6 AGE (In years last birthday) <b>52</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	2c DATE PRONOUNCED DEAD <b>January 25 1969</b>		
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>		
10. CITY OR TOWN OF DEATH <b>Towson</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Naval Ship Yard Engineer</b>			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Penna.</b>		13b. COUNTY <b>Philad.</b>		13c. CITY OR TOWN <b>Phila.</b>		13d. INSIDE CITY, Y. M. S. Y. <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>7427 Sandpiper Place</b>
14 FATHER'S NAME <b>Henry J. Behrends</b>			15 MOTHER'S MAIDEN NAME <b>Cecilia Walfer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO <b>180-10-3958</b>		17. INFORMANT <b>Robert Krause, 1820 Chestnut St., Phila., Pa.</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: <b>4109</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion Sudden</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Coronary Artery Disease 3 yrs</b> (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <b>3 yrs</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. <b>0</b> P.M. <b>0</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No <b>0</b> City or Town <b>0</b> County <b>0</b> State <b>0</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>1/25/69</b>		
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1-28-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hideside Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Roslyn, Pennsylvania</b>		
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</b>				25a. REC'D BY REGISTRAR <b>JAN 27 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b. HOUR		
JACOB			BENESCH			JANUARY 13, 1969		9:35 P.M.		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		WHITE		MAY 25, 1889		79 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
RUSSIA		U.S.A.				BALTIMORE				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			MILL FORD MANOR NURSING HOME			SALESMAN		MFG. REPRESENTATIVE		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			BALTIMORE				YES <input type="checkbox"/> NO <input type="checkbox"/>		548 SUDBROOK LANE #21208	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
ISRAEL BENESCH			JENNIE FOLB							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO.		17 INFORMANT Address					
NO			224-12-9957A		MRS. MARY BENESCH, 548 SUDBROOK LANE #21208					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u>										
DUE TO, OR AS A CONSEQUENCE OF <u>Chronic Heart Failure</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Arteriosclerotic C.V.D.</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus - Central Nervous System</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work or hot while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 13, 1965</u> , to <u>Jan 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 13, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Willard Applefeld</u>					22c. DATE SIGNED <u>1/14/69</u>					
22d. PHYSICIAN'S NAME (Type) WILLARD APPLEFELD					22e. ADDRESS 6615 REISTERSTOWN ROAD					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL			1-15-69		NEW BALTIMORE HEBREW		REISTERSTOWN, MARYLAND			
24 FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD					DATE JAN 17 1969		<u>Charles Judge</u>			



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <b>ANDREW</b>			First <b>K.</b>			Middle <b>BENNETT</b>			Last		
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>1-11-69</b>		6 AGE (In years last birthday) <b>9 YRS</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>10</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>		
10 CITY OR TOWN OF DEATH <b>Pikesville</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>4400 Old Court Road</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>NONE</b>			12b KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Balto.</b>			13c CITY OR TOWN <b>Pikesville</b>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME <b>ROGER</b>			First <b>J.</b>			Middle <b>BENNETT</b>			Last		
15 MOTHER'S MAIDEN NAME <b>STEPHANIE H.</b>			First <b>HORN</b>			Middle			Last		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b SOCIAL SECURITY NO. <b>NO</b>			17 INFORMANT <b>MR. ROGER J. BENNETT</b>			ADDRESS <b>4400 OLD COURT RD., APT. E</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital Heart Disease</b> <b>7467</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b>				EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>				22b. DATE SIGNED <b>1/20/69</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>1-21-69</b>				23c. NAME OF CEMETERY OR CREMATORY <b>OHEB SHALOM MEMORIAL PARK</b>			
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>				ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>				25a. REGD BY REISTRATION <b>JAN 22 1969</b>			
23d. LOCATION (City or Town) (County) (State) <b>REISTERSTOWN, MARYLAND</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Josephine			Bennett			Month 1 Day 25 Year 69		959 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
female		white		Nov. 2, 1881		81 YRS.		MONTHS 2 DAYS 23	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
N. J.		U. S. A.				Baltimore		Catonsville	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
SPRING GROVE STATE HOSP.				housewife					
13a. USJA. RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md. D.C.		Frederick		Hyattsville		YES		5805 Queens Chapel Road, N.E.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Daniel Holderith			Theresa			BRIGALDINE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
NO			579-62-5727J		Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) bacteremia - septicemia									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause									
(b) decubitus ulcer									
DUE TO, OR AS A CONSEQUENCE OF									
(c) generalized arteriosclerosis									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
arteriosclerotic cardiovascular disease, chronic renal disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or RFD No		City or Town		State	
22a. I certify that (X) (this hospital) attended the deceased from Sept. 30, 1968, to 1-25, 1969, that (I) (we) lost saw the deceased alive on 1-25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
J. S. Bugeon MD		1-26-69		22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		1/29/69		Holy Sepulchre Cem		EAST ORANGE N.J.			
24. FUNERAL DIRECTOR		25a. REGD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
KIERMAN FUNERAL HOME		DATE		JAN 30 1969		J. Charles Cudde			



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type in print)		First		Middle		Last		2a. DATE OF DEATH	
Carrie (Carrie)		A		BERKEMEIER				Month Day Year 7 10 29 9:30 PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		7 UNDER YEAR MONTHS DAYS	
female		caucasian		Jan. 7, 1892		77 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore, suburban		Chesapeake Manor N. Home		Social Worker					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore						3109 Weaver Ave	
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Philip		Sinclair		Mary		E		Roth	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address			
No		217-07-7657		Mrs Elizabeth A Feehley		120 Lyndale Ave			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>									<u>Today</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>CVA. - aneurysm</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/18</u> , 19 <u>68</u> , to <u>1/10</u> , 19 <u>69</u> , that <u>we</u> last saw the deceased alive on <u>1/10</u> , 19 <u>69</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>have</u> (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>ANDRUEAN MD</u>		<u>1/10/69</u>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
<u>F. ANDRUEAN</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>		<u>1/14/69</u>		<u>Parkwood</u>		<u>Baltimore Maryland</u>			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Leonard J Ruck Inc</u>		<u>Baltimore, Maryland</u>		<u>JAN 13 1969</u>		<u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \_\_\_\_\_ hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00286

00282

1 DECEASED-NAME (Type as print)		First	Middle	Last	2a. DATE OF DEATH Month		Day	Year	2b. HOUR		
Elizabeth		Anne	Berkheimer		1		2	1969	7:45 AM		
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS		IF UNDER 24 HRS HOURS MIN		
Female	White		September 11, 1968		3		3				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore,		Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b K NO OF BUSINESS OR INDUSTRY					
Towson		St. Joseph Hospital		N/A							
13a USUAL RESIDENCE (Where deceased addressed) STATE		13b COUNTY		13c CITY OR TOWN		13d HAS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland		Baltimore		YES		NO		5301 Nuth Ave.			
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Robert		Andrew	Berkheimer		Katherine		Mae	Adams			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address					
				Robert A. Berkheimer - 5301 Nuth Ave. - 21							
18 CAUSE OF DEATH (Enter on any one cause per line for (a) (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congenital heart disease with ventricular</u> <u>septal defect.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INT. RVA. BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (this hospital) attended the deceased from <u>1/2/69</u> , 19 <u>69</u> , to <u>1/2/69</u> , 19 <u>69</u> , that (we) last saw the deceased alive on <u>1/2/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.											
22b SIGNATURE		22c. PHYSICIAN'S NAME (Type)		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED			
<i>Samuel C. H. Lee, M.D.</i>		Samuel C. H. Lee, M.D.		M.D.				1/2/69			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Funeral		1-1-69		Catholics		Baltimore					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John C. Miller Inc-6415 Belair Rd.-21204				DATE		JAN 7 1969		<i>John C. Miller</i>			



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the other two. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

0028.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00283

1. DECEASED NAME (Type or Print)		First <b>ELLA</b>	Middle <b>B.</b>	Last <b>BETTEN</b>	2a. DATE KNOWN OF DEATH ESTIMATED <b>January 31 1969</b>		2b. HOUR <b>10:00 P.M.</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Sept. 28, 1880.</b>		6. AGE (In years last birthday) <b>88</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>January</b> Day <b>31</b> Year <b>1969</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore</b>			2d. HOUR <b>10:00 P.M.</b>
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Chesapeake Manor Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>2400 Ailsa Avenue</b>		
14. FATHER'S NAME First <b>George</b> Middle <b>W.</b> Last <b>Bishop</b>		15. MOTHER'S MAIDEN NAME First <b>Lean</b> Middle <b>C.</b> Last <b>Scherer</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. <b>218-50-8463</b>
17. INFORMANT <b>Harry W. Rolker, Ringtown, Pa. 17967</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of Left Hip</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>and Terminal Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION <b>12/1/69</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Hip pinning of Left Hip</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>9:00 A.M. 12/1/68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Fell on floor of Home</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>2400 Ailsa Ave Baltimore City Md</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/1/69</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/3/69.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR <b>FFB</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove farban papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P.					
Ronald Louis Betz						January 24, 1969			2:55 M					
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER YEAR MONTHS		8 UNDER 24 HRS HOURS MIN			
Male		White		December 21, 1932			36 YRS.							
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			Md.		
Maryland									Baltimore					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
Towson			St. Joseph's Hospital											
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER		
Maryland			Baltimore						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Bottom Rd. Rt. 1, Box 42		
14 FATHER'S NAME			First Middle Last			15 MOTHER'S MAIDEN NAME			First Middle Last					
Walter J. Betz						Melba N. Hyde								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
Yes			Air Force 212-32-0905			Walter J. Betz			Bottom Rd. Hydes, Md.			Box 42		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive intra-cerebral hemorrhage														
2070 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) Acute leukemia														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (X) (this hospital) attended the deceased from 1-24, 1969, to 1-24, 1969, that (X) (we) last saw the deceased alive on 1-24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED					
Reynaldo Orjuela-Gomez, M. D.									1-24-69					
22d PHYSICIAN'S NAME (Type)			22e ADDRESS											
			6220 York Rd., Towson, Md. 21204											
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
Burial			1-28-1969			St. John's Luth. Cemetery			Sweet Air, Md.					
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REG STRAR			25b REGISTRAR'S SIGNATURE					
Lassahn Funeral Home			7401 Belair Road 21236			JAN 28 1969			[Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

00283

00285

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M			
MARY BIDDISON					January 24, 1969					
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 24 HRS.			
Female	White		November 20, 1892		76 YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Pennsylvania		U.S.A.				Baltimore Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Catonsville		Summit Nursing Home		Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. since before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Howard		Ellicott City		YES		1252 Owen Brown Road		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Carl Schultheis					Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT			Address	
				218-03-2163		Mr. George Biddison			1252 Owen Brown Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Peripheral vascular collapse</u>								1 week		
4124 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio-Vascular Disease</u>								10 years		
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Diabetes mellitus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>9-30</u> , 19 <u>68</u> , to <u>1-24</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-20</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)					
<u>Thomas G. Herbert M.D.</u>		<u>1-24-69</u>			Dr. Thomas Herbert					
22e. ADDRESS		22f. ADDRESS								
		44 Church Road, Ellicott City, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		1-27-1969		Mt. Olivet Cemetery		Baltimore, Maryland				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Howard H. Hubbard, 4107 Wilkens Ave.		21229		JAN 27 1969		<u>[Signature]</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Maude				Biggs				January 23, 1969		11:30 a.	
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS	
female		white		June 22, 1890		78 YRS		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Texas		U. S.				Baltimore					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Catonsville		SPRING GROVE STATE HOSP.		housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.				Balto.				1204 Hollins Street			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
George Shultz								Joanne			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
						Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Pneumonia											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Uremia - Decubitus ulcers											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Aug. 23, 1968, to Jan. 23, 1969, that (I) (we) last saw the deceased alive on Jan. 23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE		Diomidis Pirovolidis, M.D.		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		1-23-69	
22d. PHYSICIAN'S NAME (Type)		Diomidis Pirovolidis, M.D.		22e. ADDRESS		SPRING GROVE STATE HOSPITAL					
						Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVA (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Jan. 28, 69		Moore Church of Christ		Spartanburg, South Carolina					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
		Lanford-Boyer Mortuary, Woodruff, S.C.		DATE		JAN 27 1969					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00287

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
ADOLPH		FREDERICK	BISH	JANUARY Month 13, Day 1969 Year		2:45AM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years/last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE	WHITE		AUGUST 8, 1913		55 YRS			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Mo	
MARYLAND	U.S.A.				BALTIMORE,			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON		ST. JOSEPH HOSPITAL		Chauffeur		CAB COMPANY		
13a. USLA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND		BALTIMORE				13e. STREET AND NUMBER 3125 TEXAS AVE. #21234		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		First		Middle		
George		Theresa		W		Reese		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
No		215-03-8417		Elizabeth Bish		Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage - Right</u> 431.4 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 12, 1969, to January 13, 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 13, 1969, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.								
22b. SIGNATURE Jaime M. Punzalon				22c. DATE SIGNED January 13, 1969		22d. PHYSICIAN'S NAME (Type) Jaime M. Punzalon		
22e. ADDRESS 7620 York Road				22f. ADDRESS Towson, Md. #21204				
23a. BURIAL, CREMATION, REMOVAL, (specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		1/16/69		Parkwood		Baltimore, Maryland		
24. FUNERAL DIRECTOR Leonard J. Luck Inc				ADDRESS Baltimore, Maryland		25a. DECORATED BY REGISTRATION JAN 14 1969		
						25b. REGISTRAR'S SIGNATURE [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00292

00288

1 DECEASED-NAME (Type or print) <b>BENJAMIN R. BLACK</b>			2a DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1969</b>			2b. HOUR <b>M</b>			
3 SEX <b>Male</b>		4. RACE <b>White</b>		5 DATE OF BIRTH <b>11-25-1881</b>		6. AGE (In years last birthday) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Arbutus</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>5506 Willys Avenue</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Arbutus</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>5506 Willys Avenue 21227</b>	
14 FATHER'S NAME First Middle Last <b>Benjamin I. Black</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Lucy A. Raines</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b SOCIAL SECURITY NO (If yes give war or dates of service) <b>705-05-2349</b>		17. INFORMANT <b>Mrs. Josephine L. Berry, 5506 Willys Ave.</b>		Address <b>21227</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic vavular heart disease with decompensation</b> 10 yrs. 4 4 3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Decompensation with pulmonary edema</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC			21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <b>10 yrs. plus</b> to _____, 19____, that (I) (we) last saw the deceased alive on <b>Jan. 18, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d,d) (d d not) view the body after death									
22b. SIGNATURE <b>Frederick Beitler</b>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>Jan. 20, 1969</b>		
22d. PHYSICIAN'S NAME (Type) <b>Dr. Frederick Beitler</b>					22e. ADDRESS <b>1014 Francis Avenue, Relay, Maryland</b>				
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1-23-1969</b>		23c NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Howard County, Maryland</b>			
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>					25a. REGISTRATION <b>JAN 23 1969</b>		25b. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00289

1. DECEASED-NAME (Type or print) First Middle Last <b>ALICE K BLED SOE</b>			2a. DATE OF DEATH Month Day Year <b>JANUARY 11 1969</b>		2b. HOUR <b>12:23 PM</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>7-7-81</b>		6. AGE (In years last birthday) <b>87</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE</b> Md.		
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SHANGRI-LA NURSING HOME 333 HANCOCK</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <b>STATE</b>	13b. COUNTY <b>MD</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>701 N. Chapel Gate Lane</b>	
14. FATHER'S NAME First Middle Last <b>John Kunker</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Walter</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO (If yes give war or dates of service) <b>215-10-6313</b>	17. INFORMANT <b>CHART</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A. VEMIA DUE TO? (Hgb 7.6 gm Hct 25.0)</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> , <b>NOTES: DR. H.P. BYERLY, M.D., JAN</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COVERING HIM AT PRESENT</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>See the lab</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/24</b> , 19 <b>68</b> , to <b>1/11</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>E. Kasaniti M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>1/11/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>E. KASANITI, M.D. for H.P. BYERLY, M.D. Baltimore, MD 21228</b>				22e. ADDRESS <b>1801 Frederick Rd Baltimore, MD 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>1/11/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE Md.</b>	
24. FUNERAL DIRECTOR <b>E. S. MacArthur</b>		ADDRESS <b>301 Frederick Rd Balt 20118</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 14 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00294										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00290																																																											
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																											
First Middle Last										Month Day Year										Hour Min																																																											
Simon H. Blum										Jan 19 69										12:40 A																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 MRS.																													
male										White										2-15-83										85 YRS.										MONTHS										DAYS										HOURS										MIN									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																																							
RUSSIA										U.S.A.																				Balto.																																																	
10. CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
RANDALLSTOWN										Balto. County General										SALESMAN										RETAIL																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. CITY OR TOWN										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13d. STREET AND NUMBER										APT. B #15																																							
md.										136 COUNTY										Balto										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										3916 Fordleigh Rd.																																							
14. FATHER'S NAME										15 MOTHER'S MAIDEN NAME										First Middle Last										First Middle Last																																																	
BERNARD										BLUM										SARAH										?																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17 INFORMANT										Address																																																	
NO										(If yes give war or dates of service)										215-07-0052										MRS. ETTA J. BLUM, 3916 FORDLEIGH RD., APT. B																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
157.9										Abdominal carcinoma										Possible Pancreatic Primary																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b)										(c)																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'lly medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from Dec 30, 1968, to Jan 19, 1969, that (I) (we) last saw the deceased alive on Jan 19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																															
22b. SIGNATURE										22c. DATE SIGNED										22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
Gregorio Marfon, MD										19 Jan 69										GREGORIO MARFON										BALTIMORE COUNTY GENERAL HOSPITAL																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																																	
BURIAL										1-21-69										NEW HAR SINAI										REISTERSTOWN, MARYLAND																																																	
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRATION										25b. REGISTRAR'S SIGNATURE																																																	
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD																				JAN 22 1969																																																											



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10291

10291

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1 DECEASED NAME (Type or Print)		First Vincent		Middle J.		Last Bogdan		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year Jan. 29, 1969				2b HOUR 11A M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH Aug. 24, 1911		6 AGE (in years as of birthday) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		7c DATE PRONOUNCED DEAD January 29, 1969		2d HOUR 1P. M	
7a BIRTHPLACE (State or foreign country) New Jersey		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.							
10 CITY OR TOWN OF DEATH Colgate		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. list give street address) 506 Fairview Avenue				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Steam Fitter Gas & Electric Co.				12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Colgate		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 506 Fairview Avenue					
14 FATHER'S NAME First John		Middle Bogdan		Last Bogdan		15 MOTHER'S MAIDEN NAME First Catherine		Middle ?		Last ?			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (not far time)		16b. SOCIAL SECURITY NO. 217-09-7648		17 INFORMANT (Wife) Mrs. Mary A. Bogdan, 506 Fairview Ave.				ADDRESS Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastasis to Liver, etc.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>13 mos</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.				City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> <u>Brain</u> ACTUAL SIGNATURE M.B.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Melvin B. Davis M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22b. DATE SIGNED 1/30/69 ADDRESS (Street, city, town, or county) 6800 Morningson Rd., Dundalk, Md. 21222													
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 2/1/69		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery				23d LOCATION (City or Town) (County) (State) Baltimore, Md.					
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				ADDRESS		25a REC'D BY REGISTRAR FEB 3 1969		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



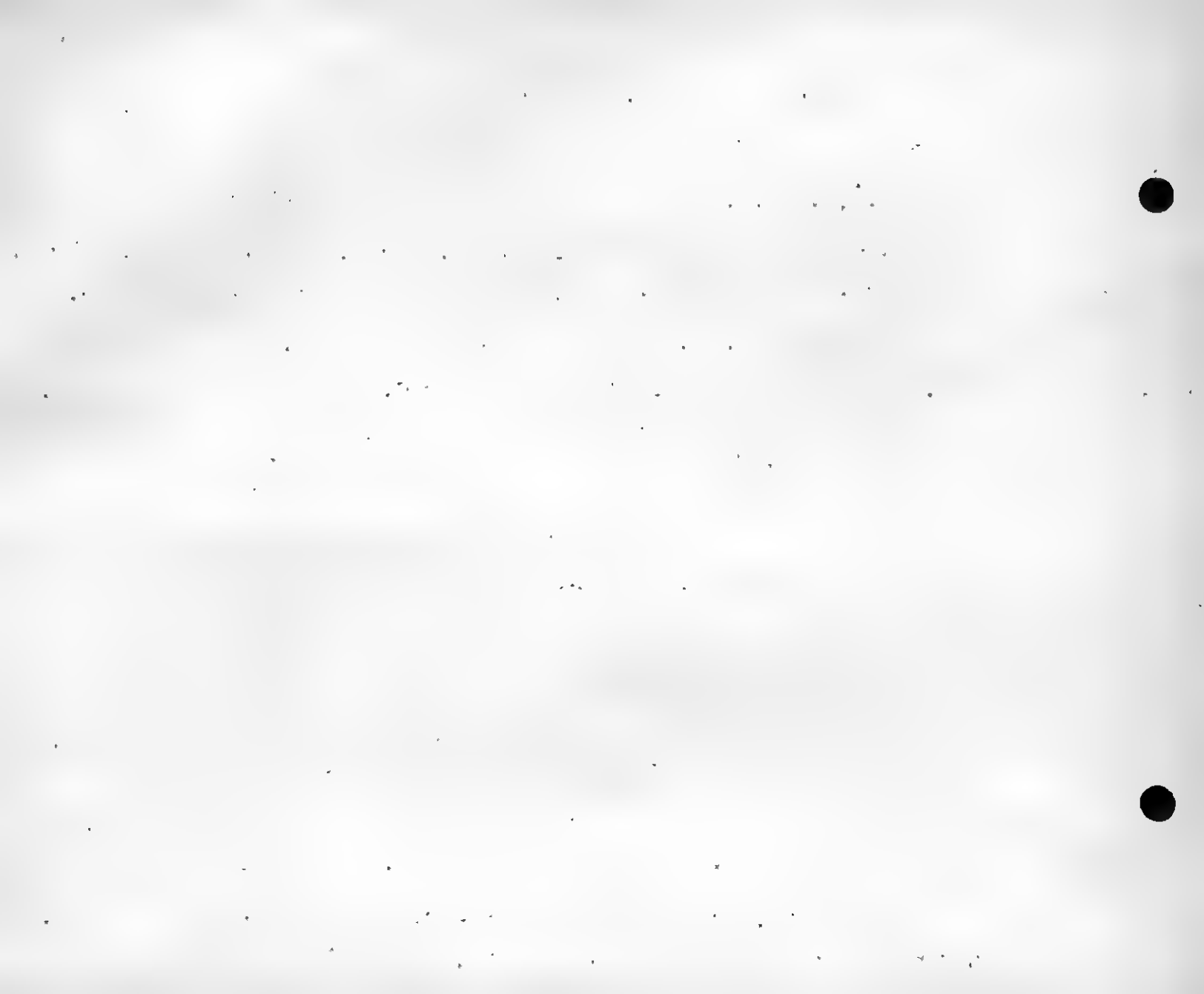
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

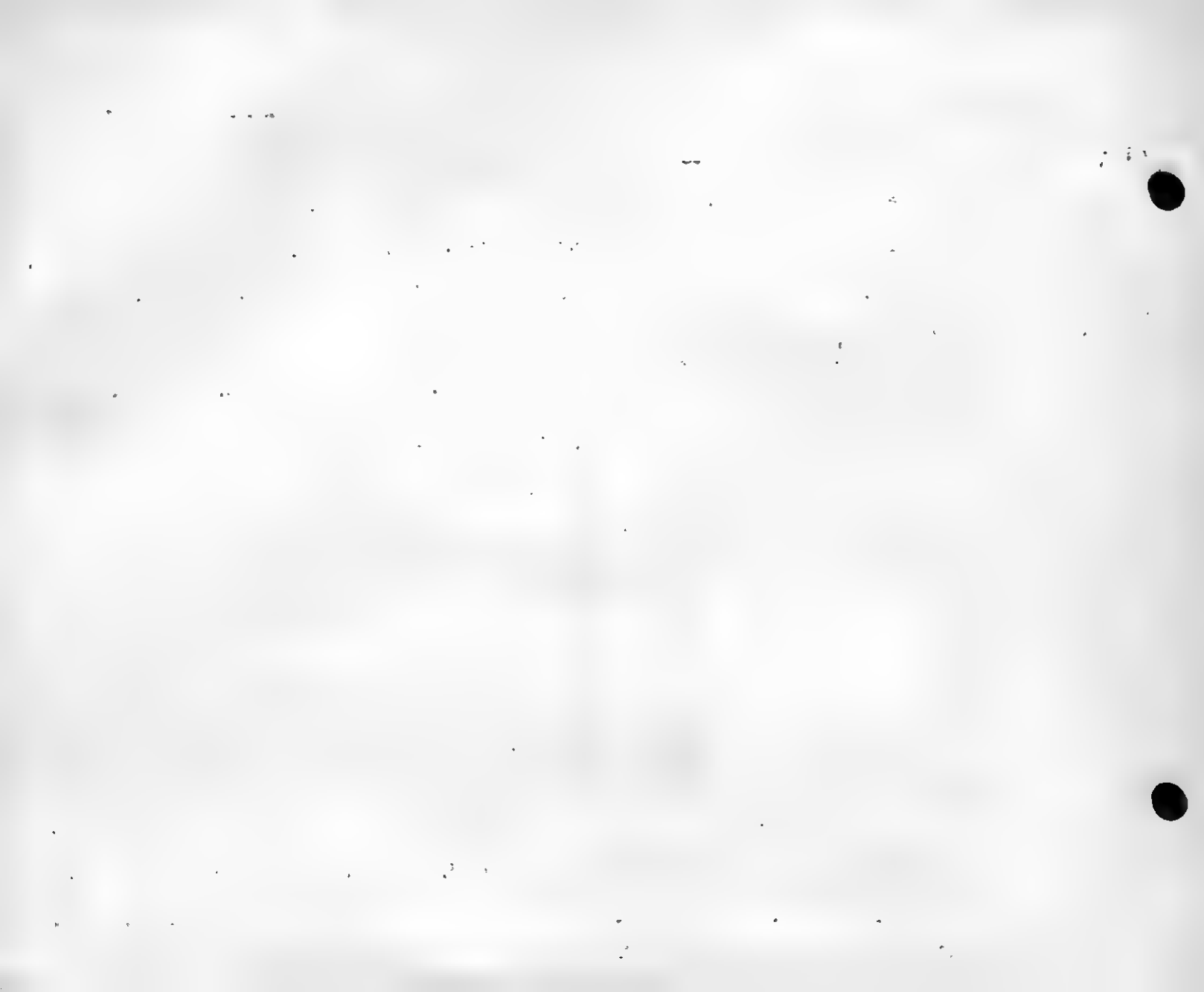
1. DECEASED NAME (Type or print)		First <b>Vernon</b>		Middle <b>A.</b>	Last <b>Bolte</b>	2b. DATE OF DEATH Month <b>1</b> Day <b>20</b> Year <b>1969</b>		2b. HOUR <b>4 P.</b> M.	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>9/15/1900</b>		6. AGE (In years last birthday) <b>68</b> YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Rodgers Forge</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>127 Dumbarton Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Supt. Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fire Dept.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Rodgers Forge</b>		13d. INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>127 Dumbarton Rd.</b>	
14. FATHER'S NAME First <b>John</b> Middle <b>E.</b> Last <b>Bolte</b>		15. MOTHER'S MAIDEN NAME First <b>Cora</b> Middle <b>K.</b> Last <b>Abbott</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>212 22 7302</b>		17. INFORMANT Address <b>Mary G. Bolte 127 Dumbarton Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(1) Arterio-sclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Hypertension secondary to Renal Ischemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>- 5 yrs.</b> <b>- 2 yrs.</b> <b>10 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Extensive arterial sclerosis of abdominal aorta</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>March 10, 1941</b> , to <b>Jan 20, 1969</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>Jan 20, 1969</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.									
22b. SIGNATURE <b>Earl L. Chambers M.D.</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/22/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>		22e. ADDRESS <b>100 W. Cold Spring Lane</b>							
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/23, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville Md.</b>			
24. FUNERAL DIRECTOR <b>Mitchell Wiedefeld Home</b>		ADDRESS <b>6500 York Rd.</b>		25a. REC'D BY REGISTRAR <b>JAN 27 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Calvert						Boswell		January 23 1969			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN	
male		white		July 22 1889		79 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Catonsville		139 Sanford Ave.		retired chauffeur		State Hosp.					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Baltimore		Catonsville				139 Sanford Ave.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Judson Boswell								Martha		Severn	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no				220 36 0652		Earl Boswell		349 Church La. Ellicott City, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Atherosclerosis Cerebral Vessel</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Age</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>2 1/2 hr</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> , 19 <u>66</u> , to <u>1/23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
CLIFFE RATHBURN, JR.						1/24/69					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
		4605 EDMONDSON AVE. #29									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		1/25/69		Mt. Olive		Randallstown Balto. Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Ellicott City, Md				JAN 28 1969							



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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b HOUR					
PAUL			EDWARD			BOWEN			January 31 1969 8.A. M					
3 SEX		4. RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		7 MONTHS		8 DAYS			
Male		White		November 30, 1897			71 YRS							
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md		
Pennsylvania			U.S.A.						Baltimore					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
Fort Howard			Veterans Adm. Hospital			Guard			Mfg. Plant					
13a USJA RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY, IN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER		
Maryland			Baltimore						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3721 Wilkins Avenue		
14 FATHER'S NAME			First Middle Last			15 MOTHER'S MA DEN NAME			First Middle Last					
PHILLIP			A BOWEN			KANNAN			JOHANNA			MULLEN		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
Yes			WW-1			169 10 08 22			Clinical Rcds VA Hospital, Fort Howard, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA										4 DAYS				
DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC BRAIN SYNDROME										YEARS				
DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL ARTERIOSCLEROSIS										YEARS				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
DECUBITUS ULCERS, MONTHS														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH			no autopsy		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY OFFICE BUILDING ETC)			21f LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (X) (this hospital) attended the deceased from May 29, 19 68, to Jan. 31, 19 69, that (1) (we) last saw the deceased alive on Jan. 31, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (aid) (do not) view the body after death.														
22b SIGNATURE						22c DATE SIGNED								
Wm Ann Orer M.D.						1/31/69								
22d. PHYSICIAN'S NAME (Type)						22e ADDRESS								
INFAN A. ORER, M. D.						VA Hospital, Fort Howard, Md.								
23a BURIAL CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
BURIAL			2-4-1969			LEADOWRIDGE CEMETERY			WASHINGTON BLVD. BALTO. MD.					
24. FUNERAL DIRECTOR						25a REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
HUBBARD FUNERAL HOME						FEB 3 1969			J. Charles Young					
4107 WILMENS AVE. BALTO.														



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SHIPPED TO: CARTER FUNERAL HOME, 925 W. BEAVER ST., JACKSONVILLE, FLA.

0029.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00295

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>LEWIS BOYNTON</b>			2a. DATE OF DEATH Month Day Year <b>1 30 69</b>		2b. HOUR <b>3:45A</b>
3 SEX <b>MALE</b>	4 RACE <b>NEGRO</b>	5. DATE OF BIRTH <b>7/18/16</b>		6. AGE (In years last birthday) <b>52</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>FLORIDA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>BALTIMORE COUNTY</b>	
10 CITY OR TOWN OF DEATH <b>FORT HOWARD</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADL. HOSP. FT HOWARD, MD.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>LEATHER CO.</b>
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>MARYLAND</b>		13b CITY OR TOWN <b>BALTIMORE</b>	13c INS DE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>709 W. BARRE STREET</b>	
14. FATHER'S NAME First Middle Last <b>ANGUS BOYNTON</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>ROBERTA COLLIER</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give branch or unknown) <b>YES WW II</b>		16b SOCIAL SECURITY NO <b>264 09 63 75</b>		17 INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH</b> <b>151.9</b> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.) DUE TO, OR AS A CONSEQUENCE OF (b) <b>BILATERAL LUNG ABSCESSSES</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street, factory, office building, etc.)		21f. LOCATION Street or RFD No. City or Town County State	
22a. I certify that (I (this hospital) attended the deceased from <b>11/16/68</b> , 19__, to <b>1/30/69</b> , 19__, that (I) (we) last saw the deceased alive on <b>1/30/69</b> , 19__, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Madhav D. Barhanpurkar</b>		22c. DATE SIGNED <b>1/30/69</b>		22d. PHYSICIAN'S NAME (Type) <b>ADHAV D. BARHANPURKAR, M.D.</b>	
22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>2-5-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET MEMORIAL CEMETERY</b>	
23d. LOCATION (City or Town) (County) (State) <b>JACKSONVILLE, FLORIDA</b>					
24. FUNERAL DIRECTOR <b>E.D. Wilson</b>		ADDRESS <b>WILSON FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>5 1969</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00296									
Item#130Film#G40 1/22/69 vmp									
1. DECEASED NAME (Type or print)			First Middle Last Alfredo A Boza			2a. DATE OF DEATH Month 1 Day 16 Year 1969		2b. HOUR 2 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec 2, 1894		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Cuba		7b. CITIZEN OF WHAT COUNTRY? Cuba		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove - Cottage 5		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admision) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Spring Grove-Cottage 5	
14. FATHER'S NAME First Middle Last Ramon Boza			15. MOTHER'S MAIDEN NAME First Middle Last Rufina Cosio						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO.		17. INFORMANT Address Ramon Boza - Spring Grove - Cottage 5				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Heart Failure</u> 4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ABHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1969</u> to <u>January 15, 1969</u> , that (I) (we) last saw the deceased alive on <u>January 15, 1969</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J. B. Ramirez</u>		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/16/69			
22d. PHYSICIAN NAME (Type)		J. B. Ramirez MD		22e. ADDRESS 3427 Annapolis Rd Baltimore Md 325 Hospital Dr Glen Burnie Md 21061					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Jan. 18-1969		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem		23d. LOCATION (City or Town) (County) (State) Baltimore Md			
24. FUNERAL DIRECTOR Farley - Carmany's Funeral Home		ADDRESS 6601 Frederick Ave. Baltimore Md 21228		25a. REC'D BY REGISTRAR JAN 20 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jaffe			



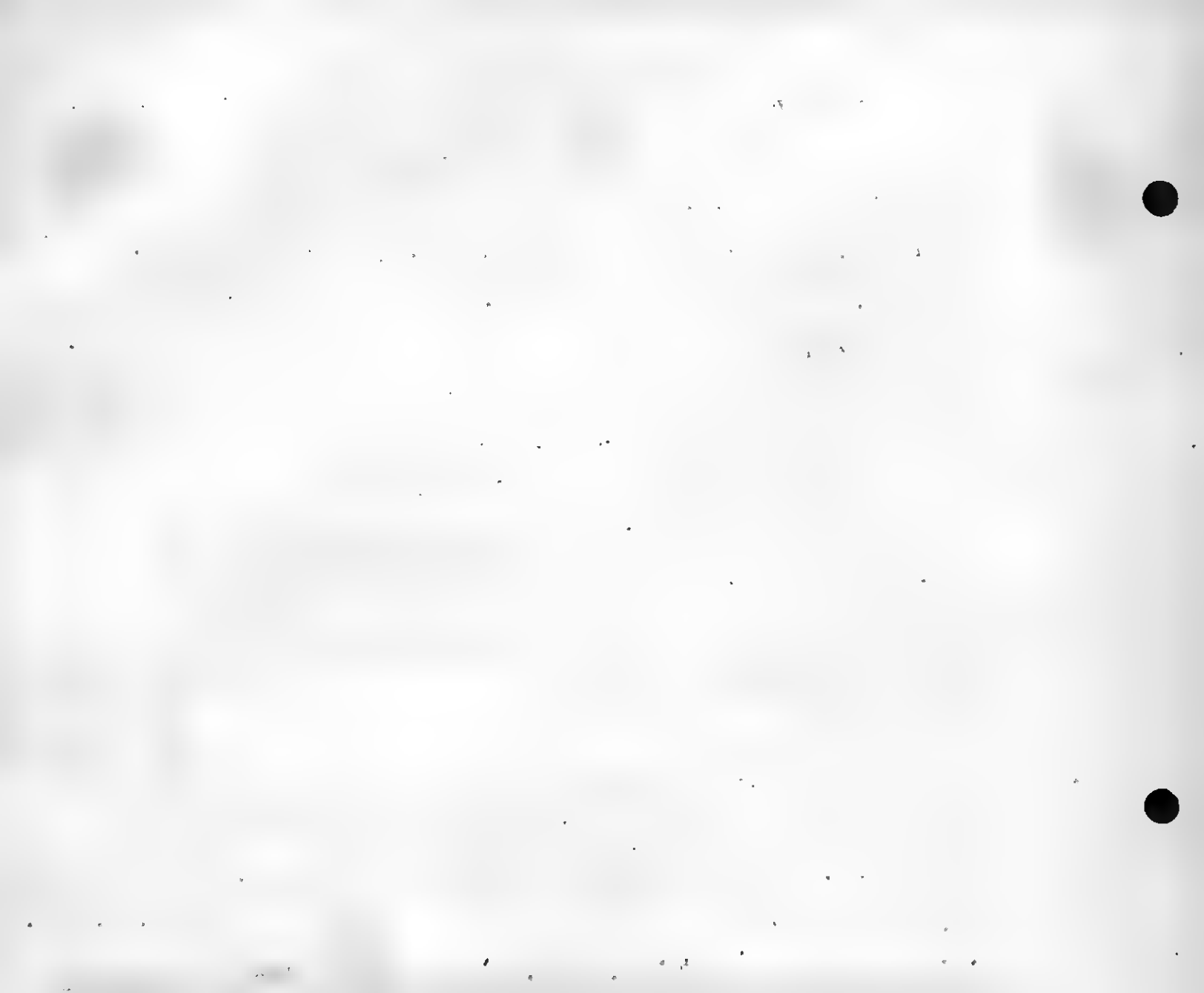
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

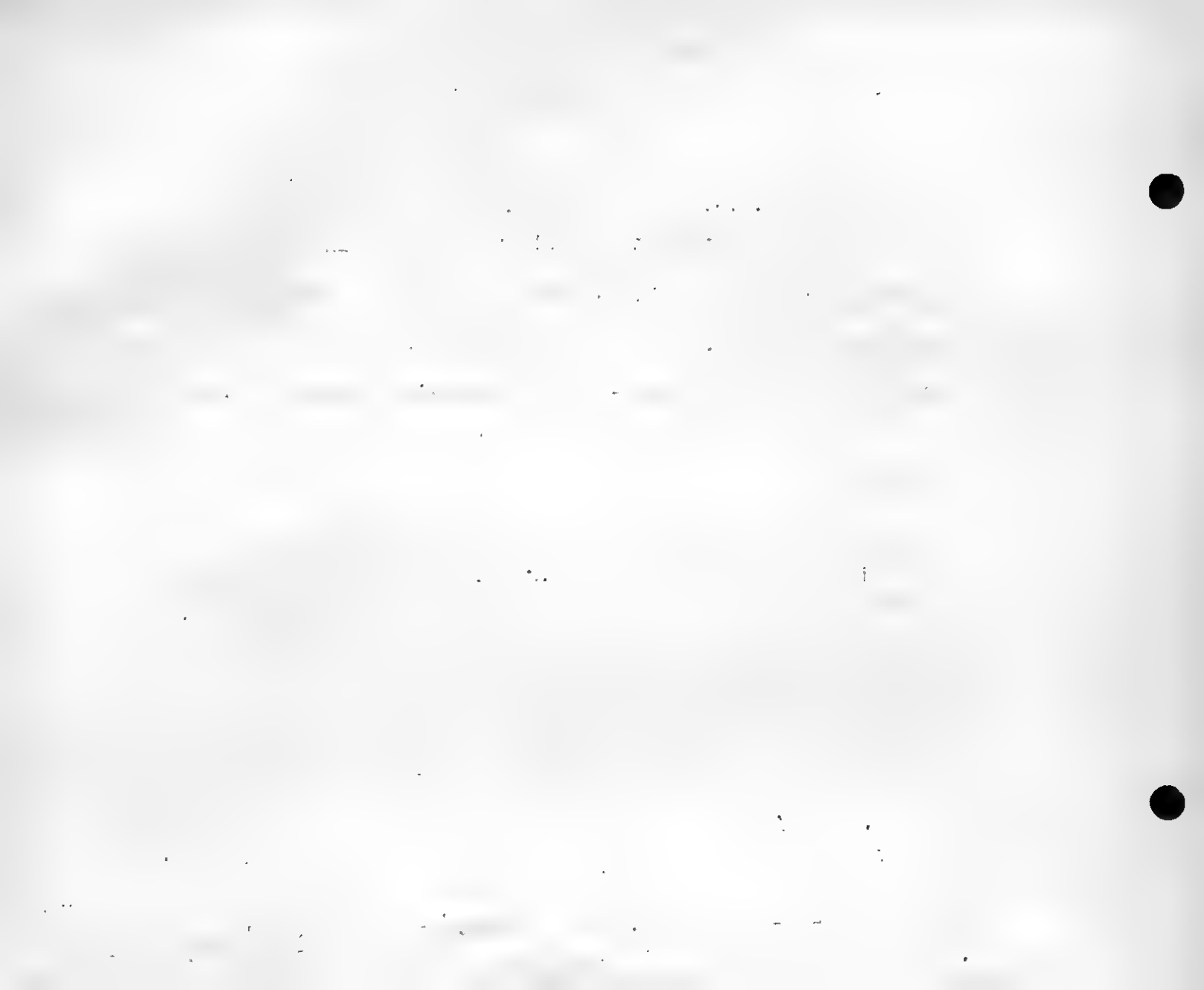
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>MINERVA ESTELLE BRADBURN</b>			2a. DATE OF DEATH 1 Month 12 Day 69 Year			2b. HOUR 4:00 PM			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>10-25-88</b>		6. AGE (In years lost birthday) <b>80</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Greater Balto. Med. Cen.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>80 Dunkirk Road</b>	
14. FATHER'S NAME First Middle Last <b>Joseph Meyers</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Fianna Mumma</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>WA-487735</b>		17. INFORMANT <b>Elizabeth Bradburn</b>		Address <b>(Same)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-pulmonary insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute myocardial ischemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arteriosclerotic cardio-vascular disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that <del>it</del> (this hospital) attended the deceased from <b>12-20</b> , 19 <b>68</b> , to <b>1-12</b> , 19 <b>69</b> , that <del>the</del> (we) last saw the deceased alive on <b>1-12</b> , 19 <b>69</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <del>had</del> (did) <del>not</del> view the body after death.									
22b. SIGNATURE <i>George Pikler, M.D.</i>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-12-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dr. George Pikler</b>		22e. ADDRESS <b>6701 N. Charles St.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/15/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Balto. Co., Md.</b>			
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd. Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 13 1969</b>		25b. REGISTRAR'S SIGNATURE <i>John Jones</i>			



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items#13d&13eFilm#G4:R 1/22/69											
1 DECEASED-NAME (Type or print) <del>First</del> <del>Middle</del> <del>Last</del> <b>EMMA Estelle BROOKS</b>						2a. DATE OF DEATH Month <b>14</b> Day <b>69</b> Year			2b. HOUR <b>9 P.M.</b>		
3 SEX <b>female</b>		4 RACE <b>caucasian</b>		5. DATE OF BIRTH <b>2/4/83</b>			6. AGE (In years last birthday) <b>85</b> YRS.			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Baltimore</b>				
10. CITY OR TOWN OF DEATH <b>Towson</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto. Med.Center</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) -----			12b. KIND OF BUSINESS OR INDUSTRY -----			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2915 Maple Avenue</b> <b>615 Chestnut Avenue</b>			
14 FATHER'S NAME First <b>John Wesley</b> Middle <b>Bailey</b> Last				15 MOTHER'S MAIDEN NAME First <b>Emma Jane</b> Middle <b>Hale</b> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>215-54-1695</b>		17. INFORMANT Address <b>Pickersgill, Same as # 13</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY <b>450 X</b> IMMEDIATE CAUSE (a) <b>Multiple pulmonary emboli</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Carcinoma of cecum with liver metastases</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that <b>(this hospital)</b> attended the deceased from <b>12/2</b> , 19 <b>68</b> , to <b>1/14</b> , 19 <b>69</b> , that <b>(we)</b> lost saw the deceased alive on <b>1/14</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <b>(I)</b> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Charles C. Brown, M.D.</b>		DEGREE		ATTENDING PHYS. <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>1/15/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Charles C. Brown, M.D.</b>		22e. ADDRESS <b>6701 N. Charles St., Baltimore 21204</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-17-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		23d. LOCATION (City or Town) <b>Parkton, Maryland</b>		(County)		(State)	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson,</b>		ADDRESS <b>1050 York Road</b>		25a. REC'D BY REGISTRAR <b>JAN 17 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00303 Item 10 Film 0409 2/7/69 kk 00299											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>Charles W. Brown Jr.</b>						2a. DATE OF DEATH Month Day Year <b>1 10 1969</b>			2b. HOUR <b>5:00 PM</b>		
3 SEX <b>Male</b>		4 RACE <b>Cau.</b>		5. DATE OF BIRTH <b>8-15-1888</b>			6. AGE (in years last birthday) <b>80 YRS.</b>			7. JUNKER 1 YEAR MONTHS DAYS <b>0 0 0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Carroll Co.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>				
10. CITY OR TOWN OF DEATH <b>Baltimore Co.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>4237 Cardwell Ave. Brakeman</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Balto. Ohio R.</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>Charles W. Brown Sr.</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Ellen Utz</b>			13e. STREET AND NUMBER <b>4237 Cardwell Avenue 36</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. <b>705-07-7855</b>			17. INFORMANT Address <b>Mrs Naomi Bittner Fork Rd. Baldwin Md. 21013</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Infarction / Myocardium due to</b> DUE TO, OR AS A CONSEQUENCE OF <b>arteriosclerotic coronary thrombosis</b> (b) <b>arteriosclerotic coronary thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF <b>Ch Brachitis - Pulmonary Emphysema</b> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) <b>gnf arteriosclerosis</b>											
19a. DATE OF OPERATION <b>Jan 30</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>gnf arteriosclerosis</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. MONTH Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1960</b> to <b>Jan 30, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan 30, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Edward W. Minter</b>						22c. DATE SIGNED <b>Jan 31 1969</b>		22d. (PHYSICIAN'S NAME (Type)) <b>EDWARD W. MINTER</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-1-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Morelan Park Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Co. Md.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>Lassahn Funeral Home 7401 Belair Road 21236</b>						25a. RECD BY REGISTRAR DATE <b>FEB 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)		First	Middle	Last		2a DATE KNOWN OF DEATH MATED		2b HOUR	
Franklin		P.	Brown, Sr.		Month 1 Day 15 Year 1969		5:15 PM		
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD		2d HOUR
M	W	2/5/1913		55 YRS			Month 1 Day 15 Year 1969		9A M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Balto., Md.		U.S.A.				Baltimore Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Riderwood			8026 Rider Ave.			Ret. Indust. Engineer		Gas & Elec. Co.	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY (M 157)	
Md.			Balto.			Riderwood		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET AND NUMBER			
George E. Brown, Sr.			Ellen Parrish			8026 Rider Ave.			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT		ADDRESS	
No			212-03-8261			Mrs. Helen N. Brown		(Same)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cessation of Heart</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Chronic Papercatosis</u> (b) <u>Chronic Papercatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6+ Months</u> <u>3 yrs +</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A M P M 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
2 d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 1/15/69			
ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/17/69		Dulaney Valley Mem. Grds.		Timonium, Balto. Co. Md.			
24. FUNERAL DIRECTOR		H.W. Jenkins & Sons Co.		4905 York Rd.		25a. REG. NO. 17 1969			
Balto. 12, Md.						25b. REG. NO. 17 1969			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF EST. DEATH MATED			2b HOUR		
MARGURITE C. BROWNE						Month Day Year			M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS M.N.	2c DATE PRONOUNCED DEAD			2d HOUR		
Female	White	March 25, 1917	51 YRS			Month Day Year			P. M.		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Maryland		U.S.A.				BALTIMORE					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a LSIA, OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Towson		(DOA) St. Joseph Hospital				Secretary			Noxema Co		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md.			—		Baltimore				3211 Bayonne Avenue		
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
James C Cannon			Florence B Henderson								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT			ADDRESS			
No			215-03-5512		James A Cannon			Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or RFD No City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			Charles S. Springate, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED		
EXAMINER'S NAME (Type)			Charles S. Springate, M.D.			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			January 23, 1969		
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			1/25/69		Moreland Memorial Park			Baltimore, Maryland			
24 FUNERAL DIRECTOR						ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Leonard J Ruck Inc. Baltimore, Maryland								DATE JAN 24 1969		Richard Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00300					00302				
1 DECEASED NAME (Type or print)					2a DATE OF DEATH			2b HOUR	
First Middle Last					Month Day Year			Hour Min	
Sarah Pratt Bryant					Jan I, 1969			I:30PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Sept 27, 1885		83 YRS.		3 4	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Mass.		U. S. A.				Towson Baltimore Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Towson - Balto.			Dulaney - Towson Nursing Home			Housewife		Own Home	
13a USUAL RESIDENCE (Where deceased lived, if institution adm ssion) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY (IM-157) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.		Balto.		Towson				111 West Rd. 607 Piccadilly	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Thomas Pratt				Elizabeth Abbott					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give dates of service)				16b SOCIAL SECURITY NO		17 INFORMANT Address			
No (None)						Family records			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 10/1/69 DUE TO, OR AS A CONSEQUENCE OF (b) PANCREATIC CANCER DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from 5/18, 1968, to 1/11, 1969, that (I) (we) last saw the deceased alive on 12/20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.									
22b SIGNATURE T.C. Siwinski					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/13/69		
22d. PHYSICIAN'S NAME (Type) T.C. SIWINSKI					22e. ADDRESS 206 W. PENNA. AV. TOWSON, Md				
23a B. RIAL, CREMATION, or REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial/cremation 1/13/69				Greenmount Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.					25a. REC'D BY REGISTRAR JAN 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Elva	Middle Lucille	Last Bryles	2a. DATE OF DEATH Month 1 Day 1969		2b. HOUR A 10:20 M		
3 SEX Female		4. RACE white		5. DATE OF BIRTH 1-3-12		6 AGE (in years last birthday) 56 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md.				
10 CITY OR TOWN OF DEATH Baltimore			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 516 Charles Street Ave.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service) None			16b. SOCIAL SECURITY NO		17 INFORMANT Husband - Roy Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable Influenza</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a))										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-30</u> , 19 <u>68</u> , to <u>1-1</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-1</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Camilo Z. Tomboc					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-1-69			
22d. PHYSICIAN'S NAME (Type) Camilo Z. Tomboc, M.D.					22e. ADDRESS 7620 York Road, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL, ETC.		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Removal for Burial Jan. 4, 1969		Waxahachie, Texas		Waxahachie, Texas						
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland					25a. REC'D BY REGISTRAR DATE JAN 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



## CERTIFICATE OF DEATH

00304

1 DECEASED NAME (Type or print) <b>NANCY</b>			First <b>LEE</b>			Middle <b>BUCHMAN</b>			Last			2a DATE OF DEATH Month <b>JANUARY</b> Day <b>5</b> Year <b>69</b>			2b. HOUR <b>10:10PM</b>					
3 SEX <b>Female</b>			4. RACE <b>White</b>			5 DATE OF BIRTH <b>4-11-47</b>			6. AGE (In years last birthday) <b>21</b> YRS.			IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>			IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>					
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Baltimore County</b> Md.											
10 CITY OR TOWN OF DEATH <b>Randallstown</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Balto. Co. Gen Hospital</b>			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Clerical</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Social Security</b>											
13a USUAL RES DENCE (Where deceased lived, if institution Res dence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>5536 Hutton Avenue</b>								
14. FATHER'S NAME First <b>Nelson</b>			Middle <b>B</b>			Last <b>BUCHMAN</b>			15. MOTHER'S MAIDEN NAME First <b>Minnie</b>			Middle <b>Oates</b>			Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT Address <b>Minnie O Buchman 5536 Hutton Ave</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 hrs</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>heart failure</b>																				
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Coron. heart dis.</b>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC						21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>1/20</b> , 19 <b>69</b> , to <b>1/3</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/3/69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <b>Milton Scheer</b> M.D. DEGREE															ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>1/6/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>Milton Scheer</b>															22e. ADDRESS <b>6410 Windsor Mill Rd</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>JAN. 8, 1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>			23d. LOCATION (City or Town) (County) (State) <b>Glenburnie AA Co Md</b>											
24. FUNERAL DIRECTOR <b>Burgee Funeral Home</b>			ADDRESS <b>Balto Md</b>			25a. REC'D BY REGISTRAR DATE <b>JAN 8 1969</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR			
NILSEN			B		BUCHANAN	1 Month 4 Day 69 Year		4 39 AM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
MALE		WHITE		3.30.18		50 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		USA				BALT. CO. MARYLAND					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
FALLS CHURCH			BALTIMORE COUNTY HOSPITAL			Nurse					
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
MD.			Baltimore		Baltimore		YES		5530 Hillside Ave. S.W.		
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Frederick					Buchanan	Alice					Bertha Hall
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address		
Yes			WWII			218 09 2532			Minnie O. Buchanan 5530 Hillside Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIA</u>											
4121 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <u>CELEBRATION WEDNESDAY LEFT CVA</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>HYPERTENSIVE ARTERIO-SCLEROTIC HEART DISEASE</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>DIABETES MELLITUS</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>1-1</u> , 19 <u>69</u> , to <u>1-4</u> , 19 <u>69</u> , that (I) (we) lost the deceased alive on <u>1-4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
[Signature]						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			14 69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
ANDREW J. [Signature]						FALLS CHURCH, VA					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			January 8, 1969		Glen Haven Cemetery		Baltimore, Maryland				
24. FUNERAL DIRECTOR			ADDRESS			25a. RECEIVED BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE		
Burger Funeral Home			Baltimore			JAN 8 1969			[Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 45M 1-1-69

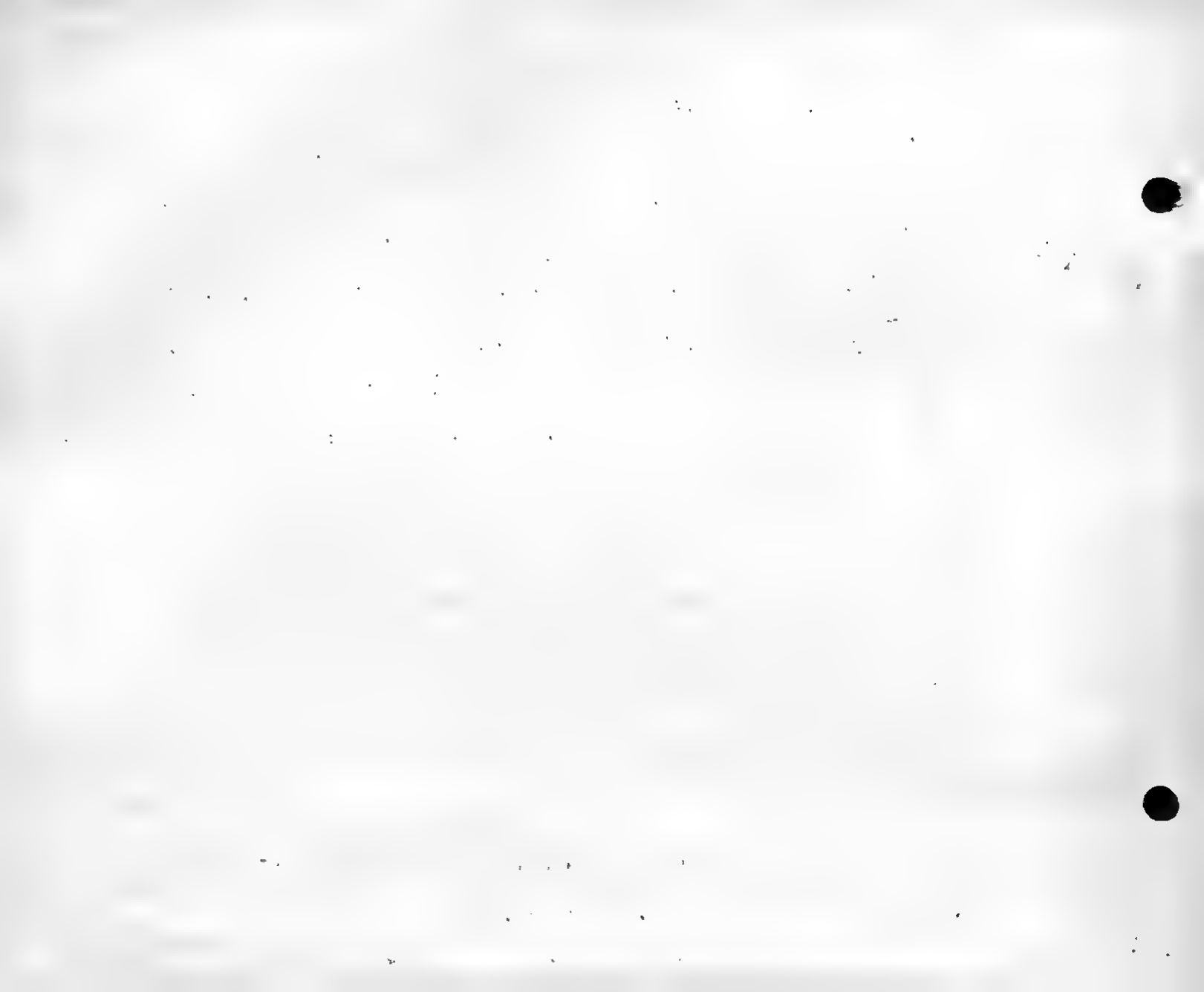
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) <u>John B Buettner</u>						2a. DATE OF DEATH <u>January 29</u> Month <u>29</u> Day <u>69</u> Year			2b. HOUR- <u>6:45</u> MIN			
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>Jan 31, 1878</u>		6. AGE (in years last birthday) <u>90</u> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u>						
10. CITY OR TOWN OF DEATH <u>Catonsville</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Summit Nursing Home</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <u>Retired</u>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Maryland</u>				13b. COUNTY <u>-</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INS. DE CITY, COUNTIES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>5118 Norwood Ave.</u>		
14. FATHER'S NAME First <u>John</u> Middle <u>Adam</u> Last <u>Buettner</u>				15. MOTHER'S M. D. N. NAME First <u>Carolyn</u> Middle <u>Grimm</u> Last <u>Grimm</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <u>No</u> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		7. INFORMANT <u>Virginia B. Schauble</u> Address <u>5203 Fernpark Ave.</u>						
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate with general metastases</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>185 X</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>lost.</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic cardiovascular disease, generalized</u>												
19a. DATE OF OPERATION <u>Sept 1968</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of the prostate</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)								
21d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>January, 1969</u> , that (I) (we) last saw the deceased alive on <u>January 28, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d) (d) view the body after death												
22b. SIGNATURE <u>Millard J. Hobart</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>1/29/69</u>				
22d. PHYSICIAN'S NAME (Type) <u>Millard J. Hobart Jr. M.D.</u>						22e. ADDRESS <u>1811 N. Rolling Rd. Balt. Md 21207</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-1-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		23d. LOCATION (City or Town) <u>Baltimore, Md</u> (County) (State)						
24. FUNERAL DIRECTOR <u>Armacost Funeral Chapel - 4600 Liberty Heights</u>						25. REC'D BY REGISTRAR <u>JAN 30 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <u>Ruth</u> <u>W</u> <u>Bullock</u>					2a DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>1969</u>			2b HOUR <u>M</u>	
3 SEX <u>F</u>		4 RACE <u>White</u>		5 DATE OF BIRTH <u>Feb. 17 1890</u>		6 AGE (In years last birthday) <u>78</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>	
7a BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>BALTIMORE</u> Md.			
10 CITY OR TOWN OF DEATH <u>Parkville</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>3332 Willoughby Rd</u>		12a USUAL OCCUPATION (Kind of work done during most of working life—even if retired.) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>MD</u>		13b COUNTY <u>BALTO</u>		13c CITY OR TOWN <u>Parkville</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <u>3332 Willoughby Rd</u>	
14. FATHER'S NAME First <u>Samuel</u> Middle <u>Waltis</u> Last <u></u>				15. MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u>Catherine</u> Last <u>Lynch</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) <u>No</u> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>HARRY L. Bullock</u> Address <u>425 McArthur ELMHURST ILL 60126</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of colon</u> <u>1058</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 196 <u>2</u> , to <u>Jan</u> , 196 <u>9</u> , that (I) (we) lost the deceased alive on <u>January 12 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J. F. Palmisano</u> MD DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>1-29-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Joseph F. Palmisano, M.D.</u>				22e. ADDRESS <u>6608 Loch Raven Blvd.</u>					
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE <u>1-31-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <u>C. F. Evans</u>				ADDRESS <u>8802 Hartford Rd</u>		25a. REC'D BY REGISTRAR <u></u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>FEB 3 1969</u>									

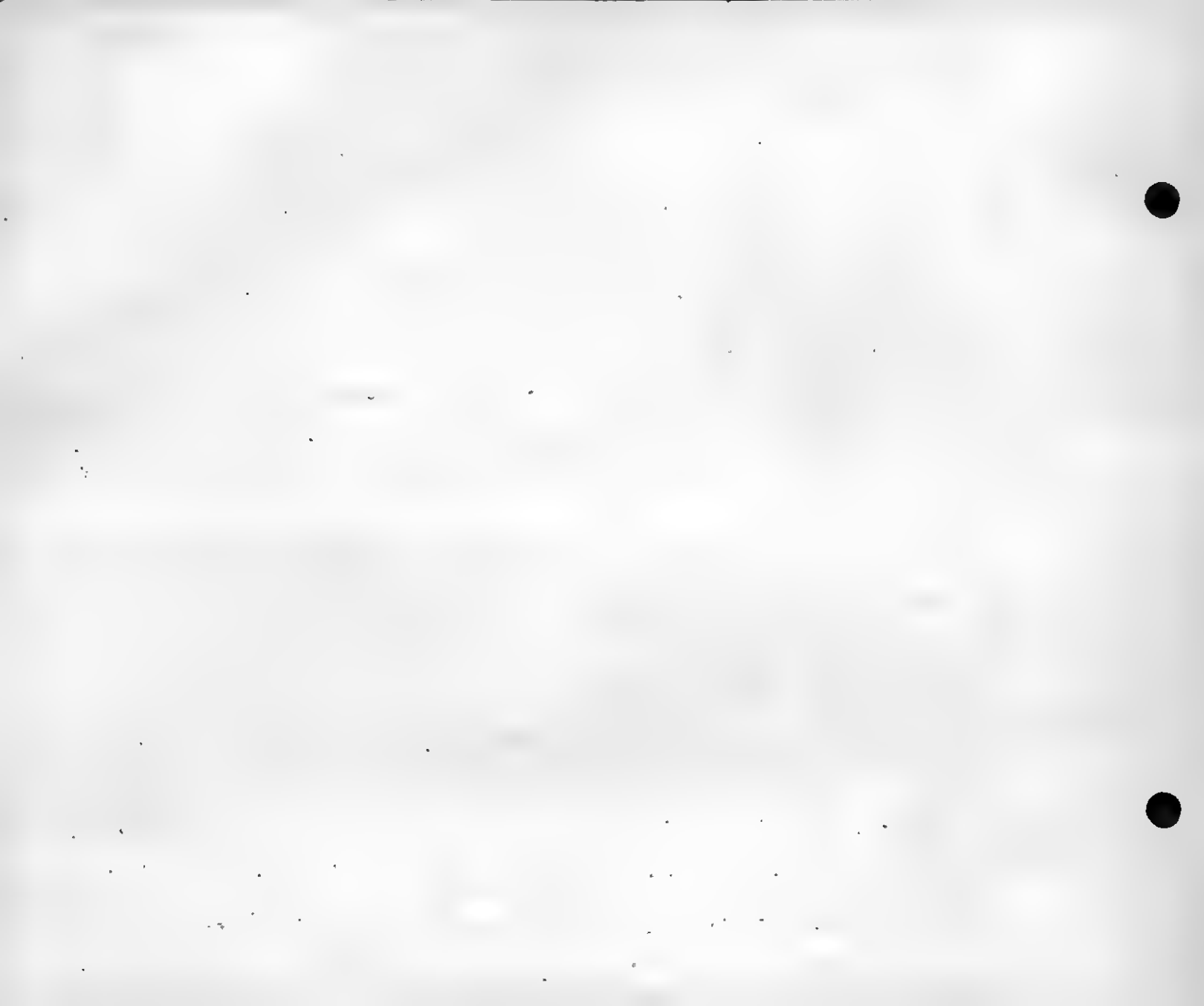


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15-10  
30M REV. 4-68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
Item #10&13a, Film G409 1/31/69 km CERTIFICATE OF DEATH 00308												
1. DECEASED-NAME (Type or print) First Middle Last MOLLIE BURKE						2a. DATE OF DEATH Month Day Year JAN 26 1969			2b. HOUR 4:30 PM			
3 SEX F		4. RACE W		5. DATE OF BIRTH SEPT 17, 1903			6. AGE (In years last birthday) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO MD						
10. CITY OR TOWN OF DEATH Pikesville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 11 SLADE AVE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY BALTO		13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 11 SLADE AVE			
14. FATHER'S NAME First Middle Last JOSEPH ROSENBLUM			15. MOTHER'S MAIDEN NAME First Middle Last ANNE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO		17 INFORMANT MORRIS BURKE			Address SAME				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis of Elderney + liver</u> DUE TO, OR AS A CONSEQUENCE OF <u>Enlargement of Colon + stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>5 yrs.</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 12, 1968</u> to <u>Jan 26, 1969</u> , that (I) (we) lost saw the deceased alive on <u>Jan 26, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Lester N. Kolman M.D.</u>					DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/27/69</u>			
22d. PHYSICIAN'S NAME (Type) LESTER N. KOLMAN, M.D.					22e. ADDRESS 3700 Park Heights Avenue							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan 27, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALTO HEBREW</u>			23d. LOCATION (City or Town) <u>BALTO</u>		(County) <u>MD</u>		(State)	
24. FUNERAL DIRECTOR Sylvan Lewis & son Inc.					ADDRESS		25a. REC'D BY REGISTRAR DATE <u>JAN 28 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

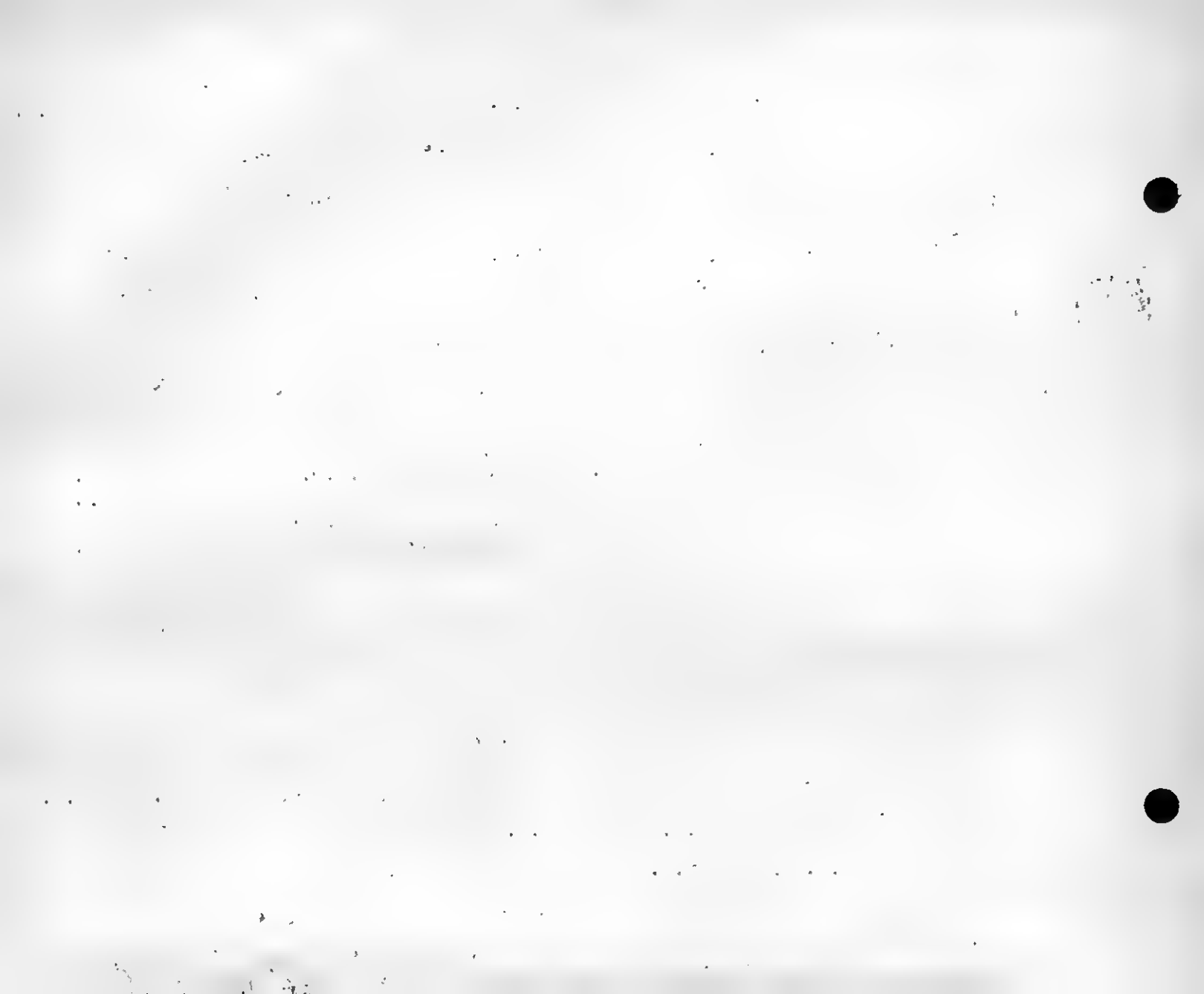
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VR 115  
30M REV

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00309

1. DECEASED-NAME (Type or print) <b>MARIE E. BURMEISTER</b>			2a. DATE OF DEATH Month <b>18</b> Day <b>1969</b> Year			2b. HOUR <b>9:30 a.m.</b>	
3 SEX <b>F</b>		4 RACE <b>W</b>		5. DATE OF BIRTH <b>6-24-1903</b>		6 AGE (In years last birthday) <b>65</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6123 MARGLENN AVE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>MD</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY (Apt)? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>6123 MARGLENN AVE.</b>		14. FATHER'S NAME First <b>JOHN</b> Middle <b>REITZ</b> Last		15. MOTHER'S MAIDEN NAME First <b>BERTHA</b> Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>-</b>		17 INFORMANT <b>Dr. Frederick W. Burmeister</b>		Address <b>- 6123 MargleNN Ave</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>4100 Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF <b>2-Arteriosclerotic C.V.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3-Diabetes mellitus</b> DUE TO, OR AS A CONSEQUENCE OF <b>4-Generalized arteriosclerosis, moderately advanced</b> (c) <b>moderately advanced</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>10 yrs. +</b> <b>6 yrs.</b> <b>10 yrs. +</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1956</b> , 19____, to <b>1969</b> , 19____, that (I) (we) lost saw the deceased alive on <b>January 8, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R.V. Rangle, M.D.</b>		22c. DATE SIGNED <b>1/20/69</b>		22d. PHYSICIAN'S NAME (Type) <b>R.V. Rangle, M.D.</b>			
22e. ADDRESS <b>2938 St. Paul Street</b>		22f. CITY OR TOWN <b>BALTO.</b>		22g. COUNTY <b>MD</b>		22h. STATE <b>MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1-22-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD</b>	
24. FUNERAL DIRECTOR <b>Edmann Funeral Home</b>		24a. ADDRESS <b>3218 Hudson St</b>		25a. REC'D BY REGISTRAR <b>JAN 21 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10311

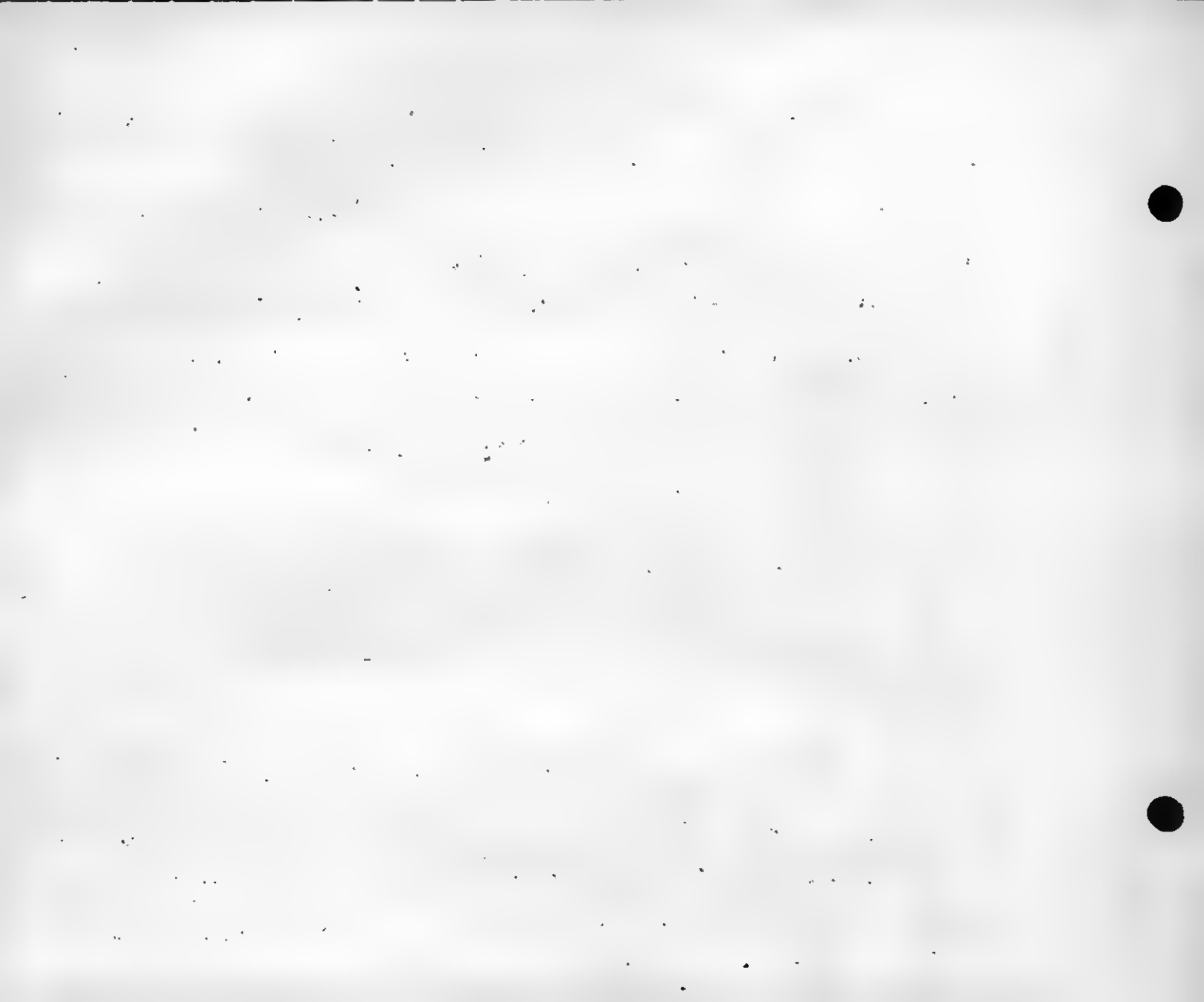
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

36310

1 DECEASED-NAME (Type or print) <b>MYRTLE BERRY BURROWS</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>2</b> Year <b>1969</b>			2b. HOUR <b>8</b> <sup>PM</sup>								
3 SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>JULY 11, 1914</b>		6 AGE (In years last birthday) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>				
7a. BIRTHPLACE (State or foreign country) <b>OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>BALTIMORE</b>			21222 Md					
10. CITY OR TOWN OF DEATH <b>DUNDALK</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8114 BULLNECK RD</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if inst tu on. Res dence before admission) STATE <b>md</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>DUNDALK</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>8114 BULLNECK RD</b>					
14. FATHER'S NAME First Middle Last <b>WILLIAM BERRY</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>AMELDA WEBB</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>			17. INFORMANT Address <b>AS IN #13</b> <b>A-E</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>4122</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>HCU</b> (b) <b>HCU</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus Exogenous obesity mark</b>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION -Street or R.F.D. No.-		City or Town		County		State				
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>68</b> , to <b>1/2</b> , 19 <b>69</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>1/2</b> , 19 <b>69</b> and that in ( <del>my</del> ) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Theodore Patterson</b>						DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4 JAN. 1969</b>						
22d. PHYSICIAN'S NAME (Type) <b>THEODORE C. PATTERSON, MD</b>						22e. ADDRESS <b>DUNDALK, Md. 21222</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1/4/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN</b>		23d. LOCATION (City or Town)		(County)		(State)				
<b>BURIAL</b>		<b>1/4/1969</b>		<b>GLEN HAVEN</b>		<b>GLEN BURNIE, Md.</b>		<b>MD.</b>		<b>MD.</b>				
24. FUNERAL DIRECTOR <b>W. Brown Bradley, Dundalk, Md.</b>						25a. REC'D BY REGISTRAR <b>DAN 8</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>8 1969</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If necessary, remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 45M 109

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

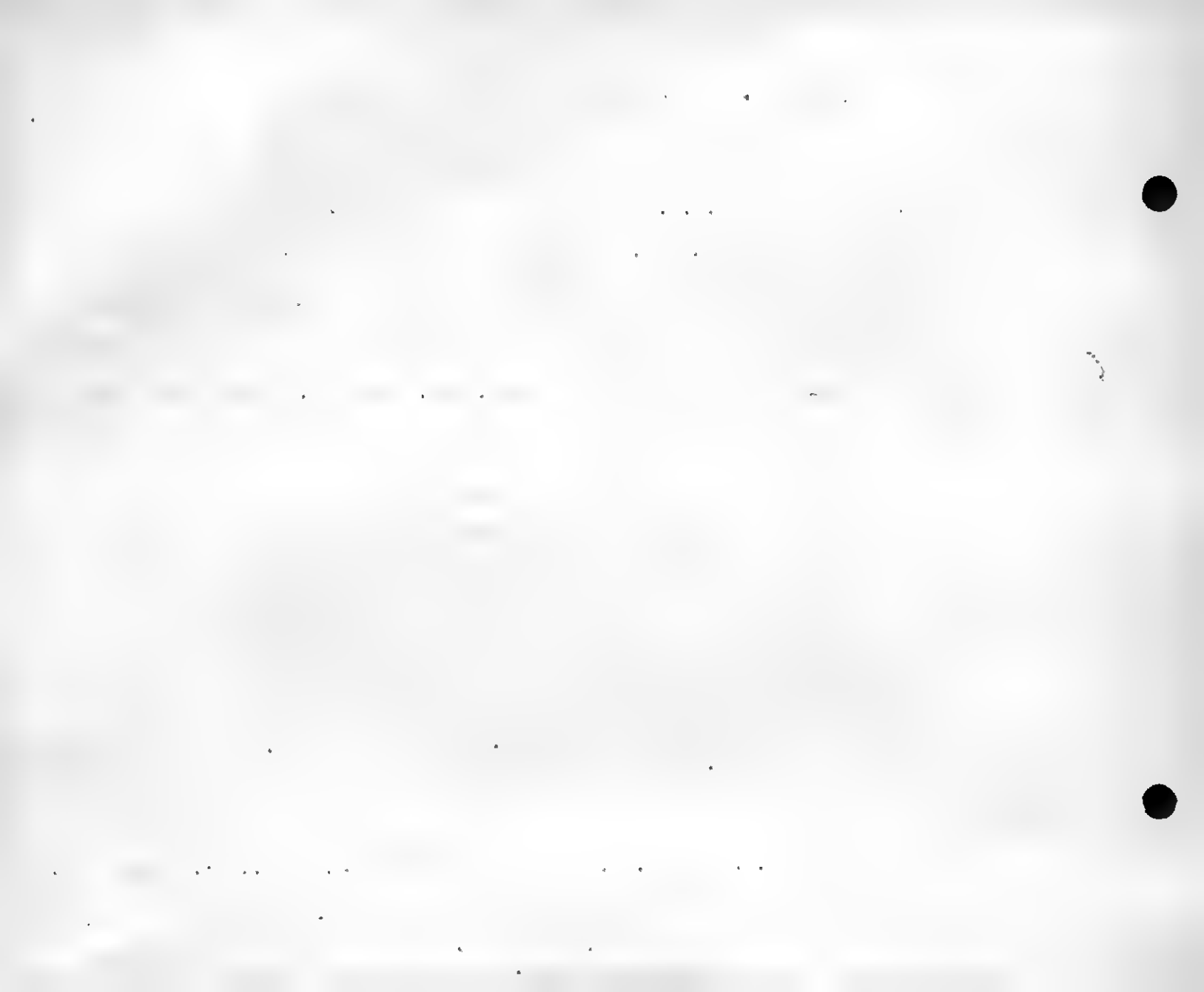
00315

00311

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First <b>FREDERICK</b>		Middle <b>JOSEPH</b>		Last <b>BURRY</b>		2a. DATE OF DEATH Month <b>JANUARY</b> Day <b>26</b> Year <b>1969</b>		2b. HOUR <b>9:45</b> a. m.	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>9 2 94</b>		6 AGE (in years last birthday) <b>74</b> YRS		7 UNDER YEAR MONTHS		8 UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> MO					
10 CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>		12a USUAL OCCUPATION (Kind of work done during year even if retired) <b>POSTAL CLERK</b>		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b COUNTY <b>BALTIMORE</b>		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>1326 HOMESTEAD STREET</b>			
14. FATHER'S NAME First <b>SAMUEL</b>		Middle <b>BURRY</b>		Last <b>BURRY</b>		15 MOTHER'S M A D E N NAME First <b>MARY</b>		Middle <b>SCHWARTZ</b>		Last <b>SCHWARTZ</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16b SOCIAL SECURITY NO (If yes give war or dates of service) <b>WW-1</b>		16c 220 44 8629		17 INFORMANT Address <b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>185X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF LEFT LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARCINOMA OF THE PROSTATE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>  <b>UNKNOWN</b>  <b>13 MONTHS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>MAINUTRITION</b>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State							
22a I certify that <del>he</del> (this hospital) attended the deceased from <b>Dec. 23, 1968</b> to <b>Jan. 26, 1969</b> , that <del>he</del> (we) last saw the deceased alive on <b>Jan. 26, 1969</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death.											
22b SIGNATURE <b>Dr. J. Parra</b>		DEGREE <b>CELJAR E. PARRA, M. D.</b>		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1 26 69</b>					
22d. PHYSICIAN'S NAME (Type) <b>CELJAR E. PARRA, M. D.</b>		22e ADDRESS <b>VETERANS ADM. HOSP., FT. HOWARD, MD.</b>									
23a BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b DATE <b>1/29/69</b>		23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>				23d LOCATION (City or Town) (County) (State) <b>BALTIMORE MARYLAND</b>			
24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b> <b>5305 Harford Rd.</b> <b>Baltimore, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 27 1969</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

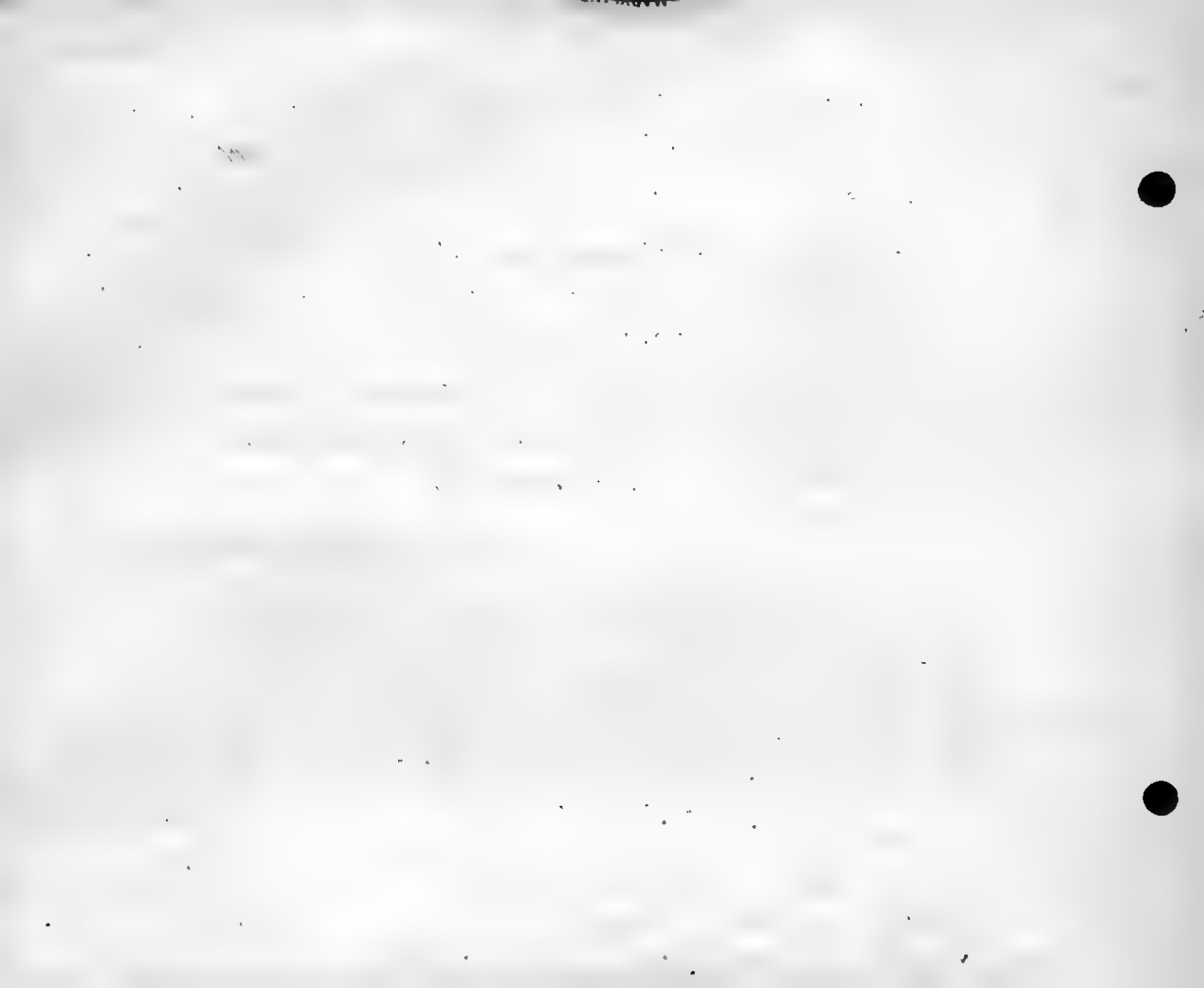
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>JOSEPHINE S BURT</b>						2a. DATE OF DEATH Month <b>JANUARY</b> Day <b>4</b> Year <b>1969</b>			2b. HOUR <b>9 P. M.</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>DEC. 17, 1889</b>			6. AGE (In years) <b>79</b> ost birthday		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>MICHIGAN</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. CITY OF DEATH <b>BALTIMORE</b>			Md.		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CHESAPEAKE MANOR N.H. HOME MAKE OWN HOME</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md</b>				13b. COUNTY <b>CHESAPEAKE</b>		13c. CITY OR TOWN <b>BALTO. 21201</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>36 WHITEFIELD Rd.</b>	
14. FATHER'S NAME First <b>JOSEPH</b> Middle <b>SPARLING</b> Last <b>MARGARET</b>				15. MOTHER'S MAIDEN NAME First <b>POTTER</b> Middle <b>POTTER</b> Last <b>POTTER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MRS. FRANK LINTHICUM (SAME)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL ARTERIOSCLEROSIS</b>										<b>5 YEARS</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>GENERALIZED ARTERIOSCLEROSIS</b>										<b>?</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from <b>JUNE 1967</b> to <b>JAN 4 1969</b> , that (I) <del>was</del> saw the deceased alive on <b>JAN 4 1969</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.											
22b. SIGNATURE <b>John M. Scott M.D.</b>				22c. ADDRESS <b>600 W. BELVEDERE AVE., BALTIMORE 21210</b>		22d. DATE SIGNED <b>JAN 4, 1969</b>					
22e. PHYSICIAN'S NAME (Type) <b>JOHN M. SCOTT</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>1/7/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>				23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 6 1969</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>					



## CERTIFICATE OF DEATH

00313

1. NAME OF DECEASED (Type or Print) <b>LUCY C. BUSICK</b>		2. DATE AND HOUR OF DEATH <b>JAN. 30, 1969 17:00 A</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>3706 MILFORD MILL RD.</b> FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE COUNTY</b> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore Maryland 21207</b> D. STREET ADDRESS (If rural, give location) <b>3706 Milford Mill Road</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 7, 1871</b>
9. AGE (In years last birthday) <b>97</b>		10. If Under 1 Yr. : If Under 24 Hrs. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Glen Rock Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward <del>Busick</del> LIEBEN</b>		14. MOTHER'S MAIDEN NAME <b>Cilenda (nee Lau)</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-58-2451</b>	
17. INFORMANT <b>Mr. H. P. Spahn 3706 Milford Mill Rd. 21207</b>		ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic heart disease</b> +100 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
22. I certify that (I) (this hospital) attended the deceased from <b>JAN. 20, 1961</b> to <b>JAN. 30, 1969</b> that (I) (we) last saw the deceased alive on <b>JAN. 15, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Abraham B. Hurwitz</b> M.D. 23C. PHYSICIAN'S NAME (Type) <b>ABRAHAM B. HURWITZ</b> M.D.		23B. DATE SIGNED <b>JAN. 30, 1969</b> 23D. ADDRESS <b>7501 Liberty Road Baltimore Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Feb. 3, 69</b>	24C. NAME of CEMETERY or CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION <b>Baltimore Maryland</b>		(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 31 1969</b>		25B. NAME OF REGISTRAR <b>Kelvinas Judge</b>	
25C. FUNERAL DIRECTOR <b>Loring Byers Chapel 8728 Liberty Rd. 21133</b>		ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, labels, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151  
45M 1 1969

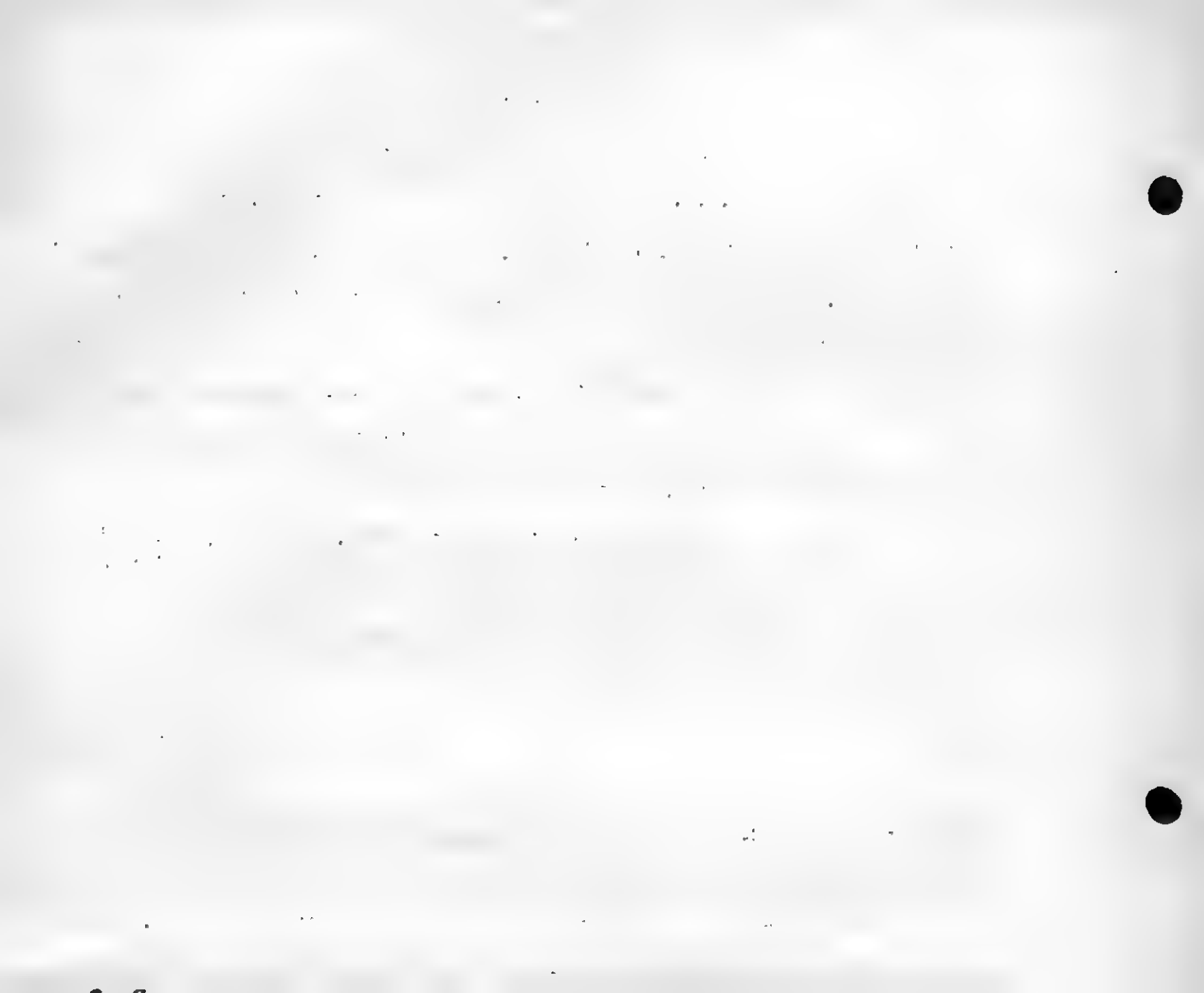
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
00318 CERTIFICATE OF DEATH 00314													
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOJR				
NORA Agnes			BUTLER			Month Day Year JAN 13 1969			7 P M				
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (n years last birthday)		7 UNDER 1 YEAR		IF UNDER 24 HRS.		
FEMALE		White		4-13-97			81 YRS		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
IRELAND			U.S.A.						BALTIMORE Md				
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
GARRISON - BALTO MD				Foxleigh Nursing Home				Practical Nurse					
13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MD.						BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		817 Evesham Ave.			
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last				
John			Butler			SARA			RYAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <u>no</u> , or (unknown)				(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
						218-34-1672		Miss Dorothy Carew 817 Evesham Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>													
4109 DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerosis</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or RFD No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>4-29</u> , 19 <u>68</u> , to <u>1-13</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>David I. Miller</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1-13-69</u>					
22d. PHYSICIAN'S NAME (Type) <u>David I. Miller</u>						22e. ADDRESS <u>9115 Reisterstown Rd. Owings Mills, Md</u>							
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			1-16-69		New Cathedral			Baltimore, Md.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212						JAN 16 1969		<u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00319										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00315																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last KATHERINE C. BUTZ										1 Month 16 Day 69 Year										8:05 PM																													
3 SEX FEMALE										4. RACE CAUCASIAN										5. DATE OF BIRTH 6-21-88										6 AGE (in years last birthday) 80 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Baltimore										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH BALTIMORE Md																			
10. CITY OR TOWN OF DEATH BALTIMORE										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT. BALT. MED. CENT										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife										12b. KIND OF BUSINESS OR INDUSTRY Housewife																			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.										13b. COUNTY Baltimore										13c. CITY OR TOWN Towson										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER 3406 Roselawn Ave 34									
14. FATHER'S NAME First Middle Last Ernest Manske										15. MOTHER'S MAIDEN NAME First Middle Last Clara K Spilling										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No										16b. SOCIAL SECURITY NO. 216-01-3495										17. INFORMANT Address Clara Odom 8716 Summit Avenue 21234									
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>2509</u> CARDIAC ARREST AND RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIO VASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS-ARTERIOSCLEROTIC HEART</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min. 4 hrs. app 30 yrs.										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DISEASE																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)										21f. LOCATION Street or R.F.D. No City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from <u>1/16</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										22b. SIGNATURE <u>R.R. J. J. J. M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 1-16-69																													
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 1-20-1969										23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery										23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.																			
24. FUNERAL DIRECTOR Lassahn Funeral Home 7501 Delair Road 21236										25a. REC'D BY REGISTRAR JAN 21 1969										25b. REGISTRAR'S SIGNATURE J. Charles Judge																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
0032.1											
00317											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		
Helen			M.		Byrnes		January 12, 1969		2b. HOUR p.m. 1:29 M		
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER YEAR MONTHS DAYS HOURS MIN		
Female		White		2-19-1899			69 YRS.				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md			
Baltimore, Md.		U.S.A.				Baltimore					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUA. OCCUPAT ON (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph Hospital			Retired - Clerk Internal Rev.					
13a USUAL RESIDENCE (Where deceased lived or institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5635 Ready Ave. 21212		
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME		
John			Byrnes						Mary		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT		Address		Way 06		
No			219-07-1076		Miss Virginia M. Young		5118		Ardmore		
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of left Breast with Metastasis											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR AM Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (A) (this hospital) attended the deceased from January 6, 1969, to January 12, 1969, that (A) (we) last saw the deceased alive on January 12, 1969, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.											
22b SIGNATURE Samuel C. H. Lee M.D.						DEGREE ATTENDING PHYSICIAN		MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED January 12, 1969	
22d. PHYSICIAN'S NAME (Type) Samuel Lee M.D.						22e ADDRESS 7620 York Road, Towson, Md. 21204					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			1/16/69		New Cathedral			Baltimore		Md.	
24 FUNERAL DIRECTOR H.W. Jenkins & Sons Co.						ADDRESS 4905 York Rd. Baltimore, Md.		25a. REC'D BY REGISTRAR JAN 14 1969		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

00318

1 DECEASED NAME (Type or print) <b>Howard Jerome CALLENDER</b>		2a DATE OF DEATH Month <b>1</b> Day <b>29</b> Year <b>1969</b>		2b HOUR <b>2:31 A M</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>May 20, 1918</b>	6 AGE (In years last birthday) <b>50 YRS</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Baltimore,</b> Md	
10 CITY OR TOWN OF DEATH <b>Towson</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Machine Opr. Black &amp; Decker</b>	12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE <b>Maryland</b>	13b COUNTY <b>Baltimore</b>	13c CITY OR TOWN <b>Baltimore</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	3e STREET AND NUMBER <b>21206 5708 Kenwood Ave.</b>
14 FATHER'S NAME First Middle Last <b>Harry Callender</b>	15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Hamill</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	16b SOCIAL SECURITY NO. <b>WW 2-Army 215-09-1441</b>	17 INFORMANT Address <b>Eleanor Krall Callender, wife, above</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive acute hemorrhage</b> <b>441</b> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ruptured dissecting aortic aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)				
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or RFD No. City or Town County State		
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1/26/</b> , 19 <b>69</b> , to <b>1/29/</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1/29/</b> , 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.				
22b. SIGNATURE 	DEGREE <b>Reynaldo Orjuela-Gomez, M.D.</b>	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c DATE SIGNED <b>1/29/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Schimunek Funeral Home, Inc.</b>	22e ADDRESS <b>3331 Brehms Lane</b>	22f ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>		
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE <b>2/3/69</b>	23c NAME OF CEMETERY OR CREMATORY <b>Balto. Nat. Cem.</b>	23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24 FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		25a RECD BY REGISTRAR <b>FEB 5 1969</b>		
45M - 1/69		25b REGISTRAR'S SIGNATURE 		



## CERTIFICATE OF DEATH

00320

00316

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. DECEASED NAME (Type or print) <i>ALICE E BURNES</i>			2a. DATE OF DEATH Month <i>Jan</i> Day <i>28</i> Year <i>69</i>			2b. HOUR <i>7:30 PM</i>	
3 SEX <i>Female</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>April 5, 1976</i>		6 AGE (In years last birthday) <i>92</i> YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore Co.</i> Md	
10. CITY OR TOWN OF DEATH <i>Catonsville</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY, IN TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>21228</i>		14 FATHER'S NAME First Middle Last <i>Patriot</i>		15 MOTHER'S MA DEN NAME First Middle Last <i>Bridget</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>	
16b. SOCIAL SECURITY NO.		17 INFORMANT		Address			
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ulcerohemorrhagic Necrosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Active ulcer on Tongue</i> (and trans, if any, which gave rise to immediate cause (a), stating the underlying cause last.) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i> <i>3 yrs</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 25, 1969</i> , to <i>Jan 28, 1969</i> , that (I) (we) last saw the deceased alive on <i>Jan 25, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <i>J. Nelson Mc Kay</i>		22c. DATE SIGNED <i>Jan 28, 1969</i>		22d. PHYSICIAN'S NAME (Type) <i>J. NELSON Mc KAY</i>		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Jan. 30 - 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Peters</i>		23d. LOCATION (City or Town) (County) (State) <i>Rome - New York</i>	
24. FUNERAL DIRECTOR <i>Cop Funeral Home New York</i>		25a. RECEIVED BY REGISTRAR <i>FEB 4 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Richard L. Indaco</i>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

10322

30319

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Old Hanover Road</u>		d. STREET ADDRESS <u>Old Hanover Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>L.</u> Last <u>Campbell</u>		4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>1969</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1901</u>
9. AGE (in years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Leather</u>		14. MOTHER'S MAIDEN NAME <u>Annie Tyson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-1835</u>	
17. INFORMANT <u>Mr. Charles C. Campbell</u>		Address <u>Boring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4109</u> IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary Heart Failure</u> DUE TO (c) <u>Atherosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u> <u>2 days</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>  </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>P. A. Knight MD</u>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>P. A. Knight MD</u>		22d. ADDRESS <u>Breedomant, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 23, 69</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hampstead, Md.</u>	
24. FUNERAL DIRECTOR <u>J. F. Eline &amp; Sons</u>		25a. REC'D BY REGISTRAR DATE <u>JA 23 1969</u>	
ADDRESS <u>Reisterstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers, pages 1 and 2, and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-1-69  
304M 1-1-69

CERTIFICATE OF DEATH

00321

00320

1 DECEASED NAME (Type or print) <b>WILLIAM J. CARLIN SR.</b>			2a. DATE OF DEATH 1 Month 25 Day 69 <sup>oor</sup>		2b. HOUR M
3 SEX <b>M</b>	4 RACE <b>W</b>	5. DATE OF BIRTH <b>1/2/1910</b>		6. AGE (In years last birthday) <b>59</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7c. COUNTY OF DEATH <b>BAIT.</b>		9. COUNTY OF DEATH <b>BAIT.</b>			
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>619 Rest Ave</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>PAINTER</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>BAIT.</b>		13c. CITY OR TOWN <b>Catonville</b>	
13d. INSIDE CITY, LIM TSP YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>619 Rest Ave</b>			
14 FATHER'S NAME <b>Edward</b>		15 MOTHER'S MAIDEN NAME <b>MARY</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>	
16b. SOCIAL SECURITY NO <b>213-09-6339</b>		17 INFORMANT <b>ANN LEPPERT</b>		Address <b>619 Rest Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD + congestive failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 yrs</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21f. LOCATION Street or RFD No City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>5-8</b> , 19 <b>67</b> , to <b>1-25</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1-25</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>James E. Rowe</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>January 27, 1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>James E. Rowe, M.D.</b>		22e. ADDRESS <b>5550 Baltimore National Pike</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1/28/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem</b>	
23d. LOCATION (City or Town) (County) (State) <b>BAIT. Md</b>		23e. REC'D BY REGISTRAR <b>JAN 28 1969</b>			
24. FUNERAL DIRECTOR <b>E.S. Mac Nabbs</b>		24b. ADDRESS <b>301 Frederick Rd Balto. 28 Md</b>			

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10325

00321

1. DECEASED-NAME (Type or Print) <u>JOHN ALVIN CARROLL</u>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>1</u> Day <u>23</u> Year <u>1969</u>			2b. HOUR <u>10A</u> M	
3. SEX <u>M.</u>	4. RACE <u>Cauc</u>	5. DATE OF BIRTH <u>June 19 1894</u>	6. AGE (In years last birthday) <u>74</u> YRS	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN	2c. DATE PRONOUNCED DEAD Month <u>Jun</u> Day <u>23</u> Year <u>1969</u>		2d. HOUR <u>11</u> M
7a. BIRTHPLACE (State or foreign country) <u>Mt. Jackson, Va.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u> Md.				
10. CITY OR TOWN OF DEATH <u>Monkton, Md.</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Monkton Rd.</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Auto mechanic</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Automotive</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Res. since before admission) STATE <u>Md.</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Monkton</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>Monkton Rd.</u>		
14. FATHER'S NAME First <u>Wm</u> Middle <u>Edward</u> Last <u>Carroll</u>				15. MOTHER'S MAIDEN NAME First <u>Sarah</u> Middle <u>Stoner</u> Last <u>Stoner</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO <u>217-03-4998</u>		17. INFORMANT <u>Mr. Cline Nelson</u>		ADDRESS <u>507 Lussuth, Towson, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <u>19</u> A.M. <u></u> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>A. M. France</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>1/23/69</u>		
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
				ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 25, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fawn Grove Meth. Cem.</u>			23d. LOCATION (City or Town) (County) (State) <u>Fawn Grove, York Co., Pa.</u>			
24. FUNERAL DIRECTOR <u>James Hartenstein, New Freedom, Pa.</u>				25a. REC'D BY REGISTRAR <u></u>		25b. REGISTRAR'S SIGNATURE <u>Richard Young</u>				
				DATE <u>JAN 27 1969</u>						

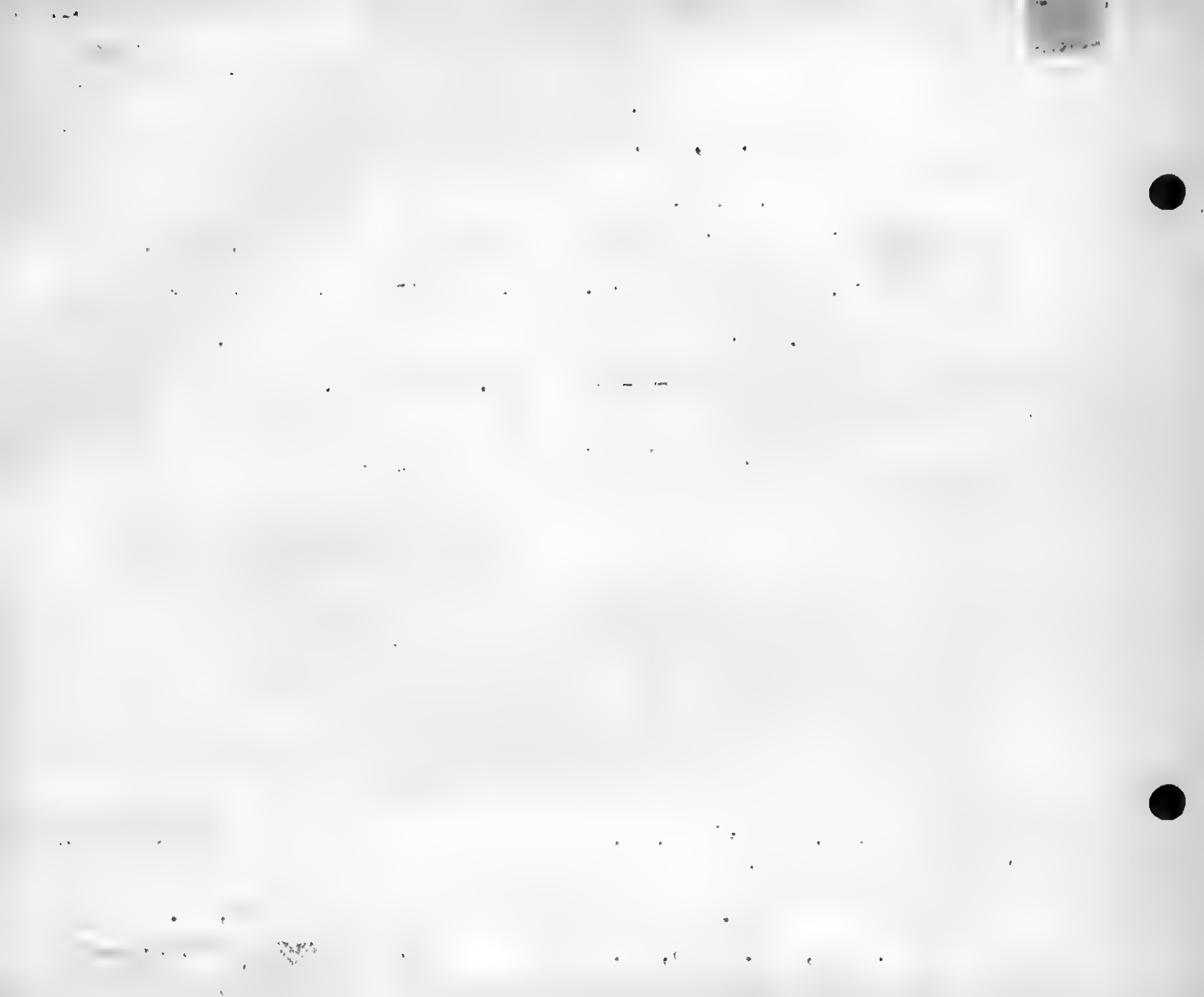


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Thomas S. Carter						Month Day Year			1 9 19 69		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR		F UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR
Male	Cauc.	Feb. 26, 1908.	60 YRS	MONTHS	DAYS	HOURS	MIN.	Month Day Year			1 9 19 69
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		U. S. A.				Baltimore county Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done - giving no most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Sparrows Point			Bethlehem Steel Hosp.			Marking Mach. Oper.			Steel.		
13a USUAL RESIDENCE (Where deceased lived, if admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Md.			Baltimore			Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7918 Highpoint Rd.	
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
First Middle Last				First Middle Last							
Dennis W. Carter				Lucretia G. Smith							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT			ADDRESS		
No				213-07-7001		Mrs. Elizabeth A. Carter			(Same)		
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriolosclerotic Cardiovascular</u>											
412.3 DUE TO, OR AS A CONSEQUENCE OF Heart Disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19								
22 INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			M. B. Davis M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED		
EXAMINER'S NAME (Type)			6800 Mornington Rd. Dundalk			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Jan. 9, 1969		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
									Baltimore - 21111		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial		1/13/69.		Fork Methodist Cemetery			Fork, Md.				
24 FUNERAL DIRECTOR						ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc. Balto. Md. 21214								JAN 13 1969		Charles J. J...	



## CERTIFICATE OF DEATH

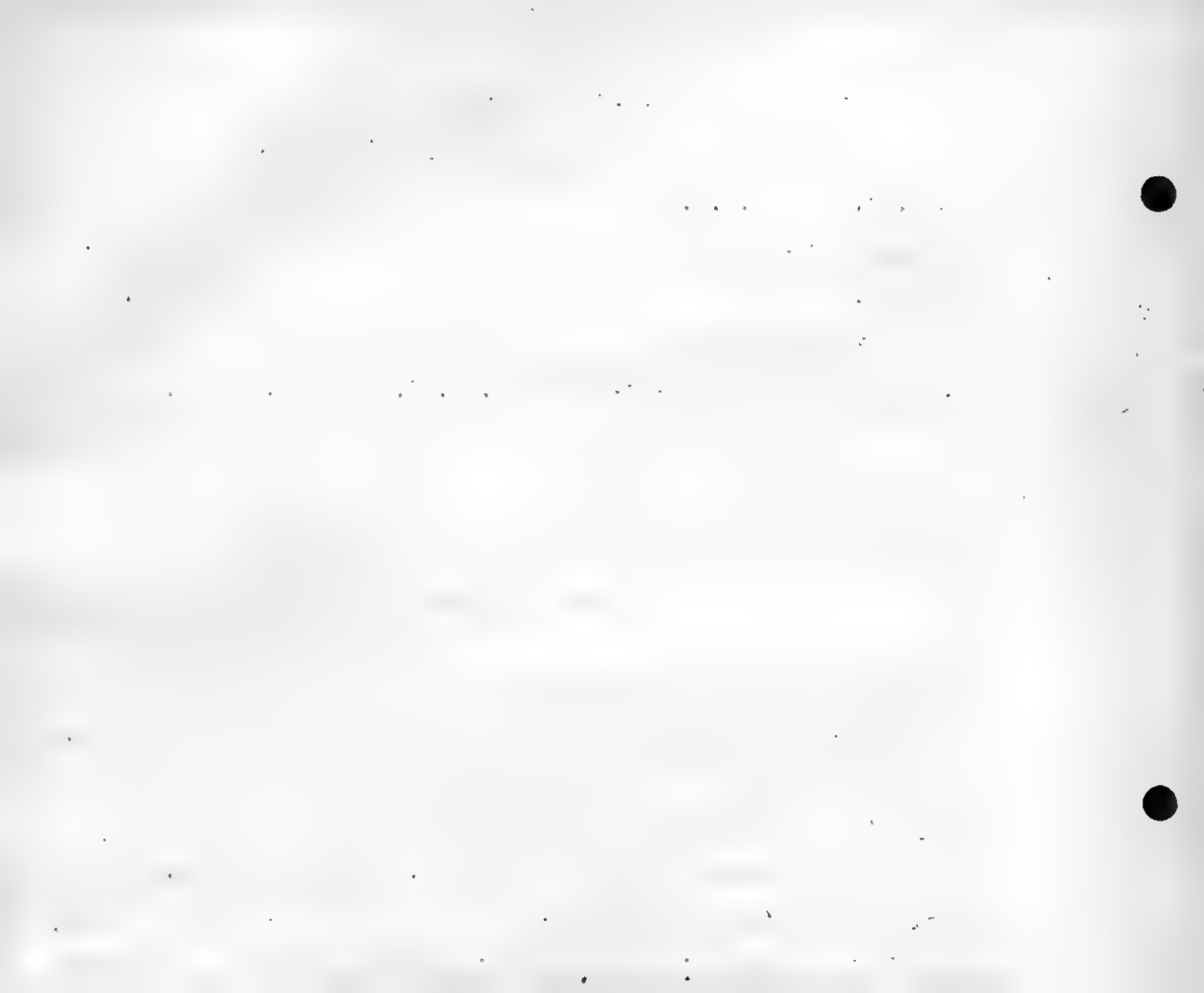
00322

00323

1. DECEASED NAME (Type or print) First Middle Last Florence Hoffman Caughy			2a. DATE OF DEATH Month Day Year January 23, 1969			2b. HOUR 5:15 A.M.	
3. SEX F		4. RACE W		5. DATE OF BIRTH July 8, 1870		6. AGE (In years lost birthday) 98 YRS.	
7a. BIRTHPLACE (State or foreign country) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Baltimore 21212		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Armaccost Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER Broadview Apts.		14. FATHER'S NAME First Middle Last Emory Hoffman		15. MOTHER'S MAIDEN NAME First Middle Last Annie Gibson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-48-4142		17. INFORMANT Address Mrs. J. I. Hopkins, 3900 N. Charles St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured abdominal aortic aneurysm</u> 4 1/2 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hrs 3 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/13/69</u> , 19 <u>69</u> , to <u>1/23</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>1/23/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Francis W. Gluck MD</u>		22c. DATE SIGNED <u>1/24/69</u>		22d. PHYSICIAN'S NAME (Type) Dr. Francis W. Gluck			
22e. ADDRESS 100 W. University Pkwy.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/25/69		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.		25a. REC'D BY REGISTRAR DATE JAN 27 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
KONSTANTY				CELMER	JANUARY Month 28, Day 1969		2:00 PM	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White		March 17, 1884		84 YRS	MONTHS DAYS		HOURS MIN
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
Poland	U.S.A.			BALTIMORE,				
1d CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
TOWSON		ST. JOSEPH HOSPITAL		Farmer		Farm		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER		
MARYLAND		BALTIMORE		Essex 21221	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	365 Mitchell Rd. #21221		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S M A DEN NAME		First	Last
Unknown					Unknown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address		
No		214 20 9514 A		Jess Celmer		3601 Fait Ave. Baltimore, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hremia</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Chronic pyelonephritis</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, term B.)				
		HOUR A.M. Month Day Year P.M. 19						
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>January 21, 1969</u> , to <u>January 28, 1969</u> , that (I) (we) last saw the deceased alive on <u>January 28, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE				22c DATE SIGNED				
<u>Jaine Punzalan M.D.</u>				1-28-69				
22d PHYSICIAN'S NAME (Type)				22e ADDRESS				
Jaine Punzalan, M.D.				7620 York Road, Towson, Md. 21204				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		2/1/69		St. Stanislaus Cemetery		Baltimore, Maryland		
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR 1969 25b. REGISTRAR'S SIGNATURE		
Bruzdzinski Funeral Home				1407 Eastern Ave.		JAN 31 1969		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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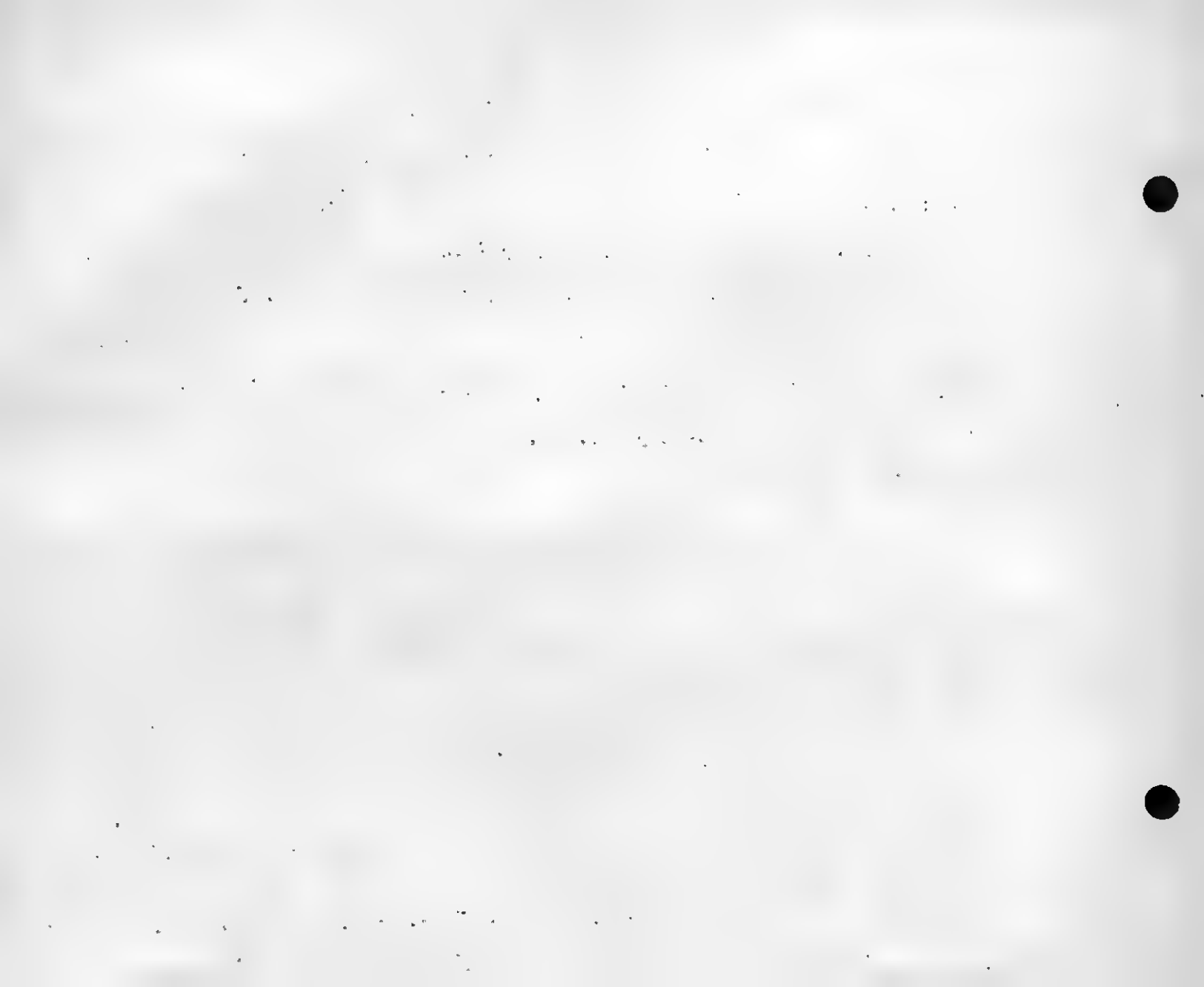
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Ethelwyn					Charles	1 5 1969			7.55 PM
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
Female		White		Oct. 27, 1872		96 YRS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Chicago, Ill.		United States				Balto. Co.		Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Towson, Md.		Dulaney-Towson Nursing Home		Teacher					
13a USUAL RESIDENCE (Where deceased lived, admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Ill.		Cook		River Forest				x River Forest, Illinois x Bon Spring, Md. Timonium	
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Thomas					Charles	Harriett Blood			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address
No						Hafriett Clapp			Timonium Md.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardio vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mons. 5 yrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Bronchitis</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <u>29 November, 1966</u> , to <u>January, 1969</u> , that (I) (we) lost saw the deceased alive on <u>3 January, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <u>not</u> view the body after death.									
22b SIGNATURE <u>Walter J. Kees</u>						22c DATE SIGNED 5 January 1969			
22d. PHYSICIAN'S NAME (Type) <u>Dr. Walter Kees</u>						22e ADDRESS <u>Cockeysville Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
Cremation		Jan. 6, 1969		Green Mount Crematory		Baltimore, Maryland			
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, 1050 York Road</u> <u>Towson, Maryland 21204</u>						25a. REC'D BY REG. STRA. <u>1969</u>		25b. REC'D BY REG. STRA. <u>1969</u>	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
GEORGE A. CHETELAT						Month 1 Day 8 Year 69			9 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		E. UNDER 1 YEAR MONTHS		F. UNDER 24 HRS. HOURS	
MALE		WHITE		MARCH 16-1894		74 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				BALTIMORE Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
CATONSVILLE			5743 EDIMONDSON AVE			CARPENTER			CONSTRUCTION		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD.			BALTO.		BALTIMORE				318 EDGEWOOD ST.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
FRANK CHETELAT			DIERLING								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
YES			W.W.1		217-093685		MARGARET SEWELL 152 IRVING ST.				
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>										1 day	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1 Oct</u> , 19 <u>69</u> , to <u>3 Jan</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2 Jan</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William Goodman</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10 Jan 69</u>			
22d. PHYSICIAN'S NAME (Type) <u>WILLIAM Goodman, MD</u>						22e. ADDRESS <u>1324 Tulphinstone Rd</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL			1-13-69		BALTIMORE NATIONAL		BALTIMORE		MD.		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
WALTERS FUNERAL HOME PRATT & STRICKER ST.						DATE <u>JAN 13 1969</u>					



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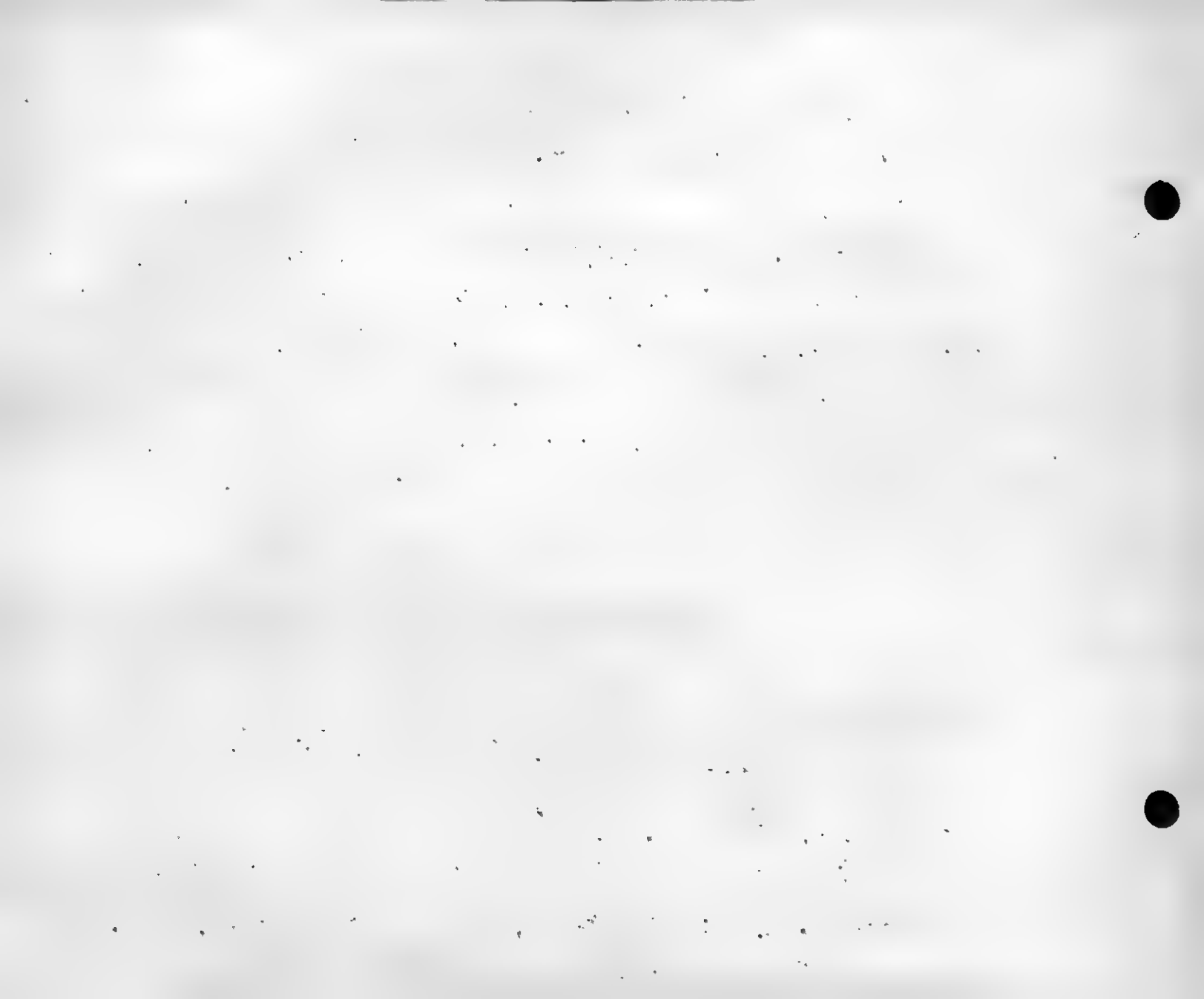
VR A15  
30M REV 1-66

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00327

1. DECEASED-NAME (Type or print) <b>ETHEL Patterson CLAPP</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>5</b> Year <b>69</b>		2b. HOUR <b>11:25</b> M
3 SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH <b>11-18-1893</b>		6. AGE (In years last birthday) <b>75</b> YRS.	IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE</b> Md.		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CHESAPEAKE MANORS</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>Alleghany</b>	13c. CITY OR TOWN <b>CUMBERLAND</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>648 Fayette Street</b>	
14. FATHER'S NAME First Middle Last <b>William Thomas Barnes</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Ida May Patterson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give date or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO <b>NONE</b>	17. INFORMANT <b>Family Records</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF <b>Carcinoma of Lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3wks</b> (c) <b>3yrs</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 1965</b> , to <b>5 January 1969</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>4 January 1969</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <b>Charles F. O'Donnell</b>		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <b>CHARLES F. O'DONNELL</b>		22e. ADDRESS <b>7001 YORK RD., TOWSON, MD.</b>		22c. DATE SIGNED <b>5 January 69</b>	
23a. BURIAL, CREMATION, REMOVAL, SPECIFY <b>Burial/Removal</b>	23b. DATE <b>Jan. 8, 1969</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR <b>John Burns Ans</b>		ADDRESS <b>Towson Md.</b>		25a. REGD. BY REGISTRAR <b>JAN 13 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



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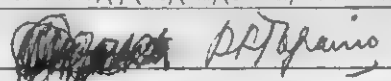
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Grace						Clarkson		Jan 20 1969		1:00 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		white		11/25/1875		94 2/3 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore		U.S.				Baltimore Co.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Hennepin Nursing Home		Housewife							
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.				Baltimore				727 E. Lake Ave			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
John H. Barker		Matilda Barker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown?		16b. SOCIAL SECURITY NO		17. INFORMANT				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>										2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral-vascular accident</u>										5 days	
(c) <u>Arteriosclerotic Cardio-Vasc Dis</u>										10 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1967</u> to <u>Jan 20, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 19, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED					
George Sawyer M.D.						Jan 20, 69					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
GEORGE SAWYER, M.D.		4808 Harford Rd. Baltimore									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		I-27-1969		Mount Olivet Memorial		SUNNYVALE CALIFORNIA					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
WALTER DABROWSKI		1005 DUNDALK AVENUE		JAN 22 1969		[Signature]					



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VR 1-1-69  
304M 1-1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
00330									
1. DECEASED-NAME (Type or print)		First Charlotte M Middle Clyde Last			2a. DATE OF DEATH 012 Month 14 Day 69 Year			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10-19-18		6. AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) na		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto Co Gen Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3107 Gartside Ave.	
14. FATHER'S NAME First na Middle Francis L. Mills Last		15. MOTHER'S MAIDEN NAME First na Middle Orie Bortner Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO (If yes give war or dates of service) ---		17. INFORMANT Address 215.09.6496 Mr. Victor E. Clyde-3107 Gartside Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) - Acute Respiratory Insufficiency 3 days. 491X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) - Chronic Bronchitis and Emphysema. YEARS. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (th's hospital) attended the deceased from 1-13, 19 69, to 1-14, 19 69, that (I) (we) last saw the deceased alive on 1-14, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 		22c. DATE SIGNED 1-14-69		22d. PHYSICIAN'S NAME (Type) ANGELITA A. TOPACIO		22e. ADDRESS BALTO. COUNTY GEN. HOSP.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 17, '69		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Woodlawn Balto. Md.			
24. FUNERAL DIRECTOR John P. Stansbury		25a. REC'D BY REGISTRAR JAN 16 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

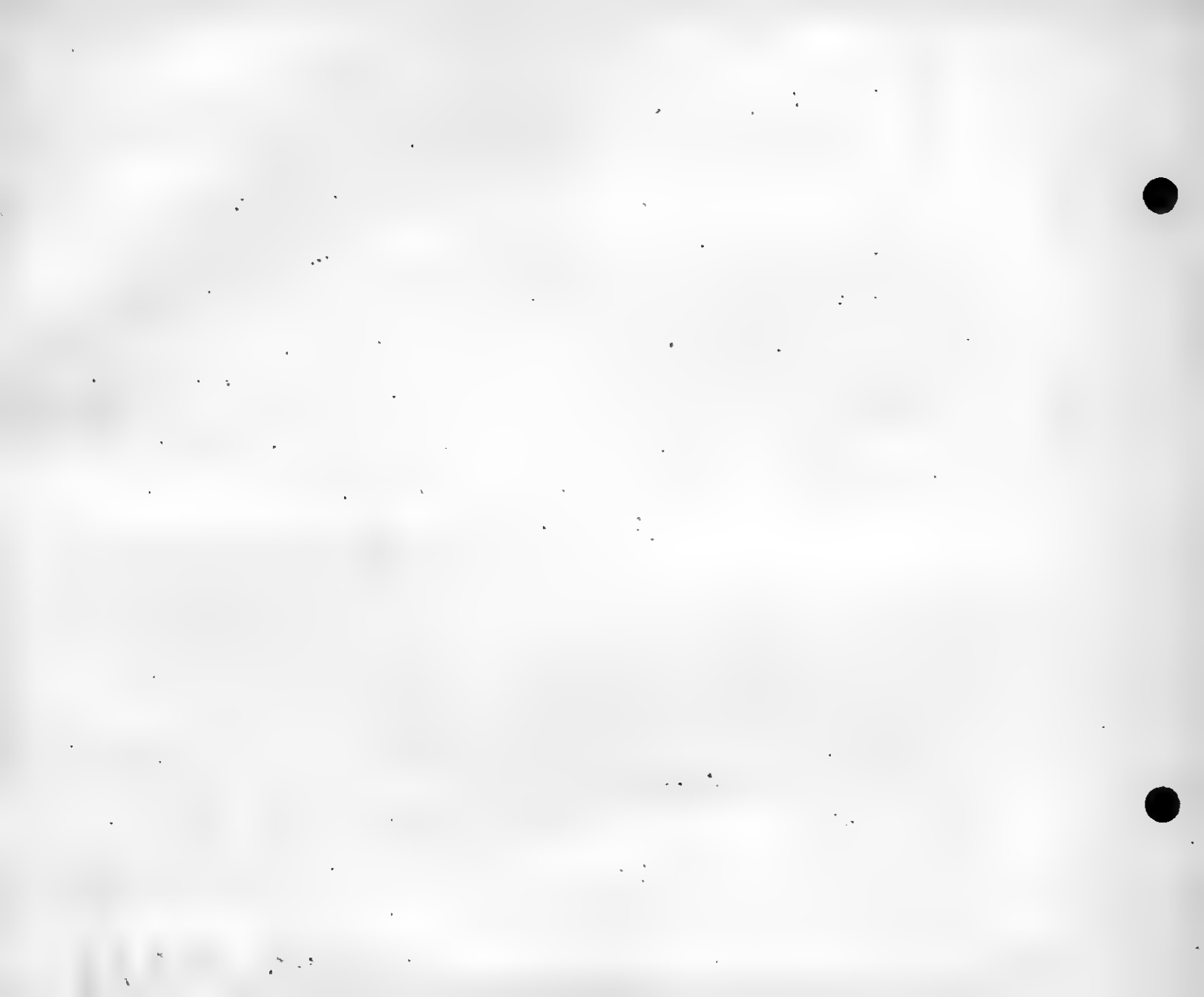
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

00334

00330

1. DECEASED-NAME (Type or print) <b>MARY R. COLL</b>			First Middle Last			2a. DATE OF DEATH Month Day Year <b>1/13/69</b>			2b. HOUR <b>9:30</b> M			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>7/25/1888</b>			6. AGE (In years last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTO</b> Md.						
10. CITY OR TOWN OF DEATH <b>RELA</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1548 S. ROLLING RD HOUSE 1116</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>RELA</b>		3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1548 S. ROLLING RD</b>			
14. FATHER'S NAME <b>EDWARD J. TURNER</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>REBECCA FAITH</b>			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give year or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT <b>JOHN COLL</b> Address <b>1548 S. Rolling Rd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio Vascular Disease</b>										5-4/69		
2509 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes Mellitus</b>										10-4/69		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>Chronic Arteriosclerosis</b>										10-4/69		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (1) (this hospital) attended the deceased from <b>3</b> , 19 <b>60</b> , to <b>1/13</b> , 19 <b>69</b> , that (1) (we) last saw the deceased alive on <b>1/12</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death												
22b. SIGNATURE <b>B.B. Brumbaugh MD</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>1/13/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>B.B. Brumbaugh</b>						22e. ADDRESS <b>3609 Main St ECHMUNDA MD</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>1/16/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>GRAVE</b>			23d. LOCATION (City or Town) (County) (State) <b>HEWARD CO. MD</b>			
24. FUNERAL DIRECTOR <b>E.S. MACNABB</b> ADDRESS <b>21228</b>						25a. REC'D BY REGISTRAR <b>JAN 17 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00333

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

00331

1 DECEASED-NAME (Type or print) <b>Myrtle Gertrude Connolly</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>8</b> Year <b>1969</b>			2b. HOUR <b>10 47 AM</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>November 27, 1893</b>		6 AGE (In years last birthday) <b>75</b> YRS		7 UNDER YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore,</b> Md			
10 CITY OR TOWN OF DEATH <b>Towson</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Balte.</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>9628 Alda Dr.,</b>	
14 FATHER'S NAME First <b>John Hurley</b> Middle <b>Theresa O'Connor</b> Last			15 MOTHER'S MAIDEN NAME First <b>Theresa O'Connor</b> Middle Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			
16b SOCIAL SECURITY NO			17 INFORMANT Address <b>Eileen Wallbillick, 9628 Alda Dr.</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Carcinoma of lung</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No		City or Town		County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/20/</b> , 19 <b>68</b> , to <b>1/6/</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>1/6/</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Lorna Gaudiel, M.D.</b>		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>		22e. DATE SIGNED <b>1/6/69</b>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>1-9-69</b>		23c NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d LOCATION (City or Town) (County) (State) <b>Balto., Md.</b>		23e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>		24b ADDRESS		25a REC'D BY REGISTRAR DATE <b>JAN 8 1969</b>		25b REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Arthur Robert Cook, Jr.						1 Month 1 Day 69 Year			7:55 A.M.		
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (in years last birthday)		7 IF UNDER 1 YEAR		
Male.		White.		8-27-94			69 YRS		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED			9 COUNTY OF DEATH		
Mass			U.S.A.			NEVER MARRIED			Baltimore County Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cotonsville			Spring Grove State Hospital			Hospital, Carpenter					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INS DE CITY, TOWNSHIP		
Maryland			Hartford			Aberdeen			YES NO		
14 FATHER'S NAME			15 MOTHER'S M.A.DEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO		
Robert A. Cook			Ada			Yes, no, or unknown			921-03-6024		
17 INFORMANT			18 ADDRESS			19			20		
Charles Spring Grove State Hospital			Pase								
1B CAUSE OF DEATH (Enter only one cause per box for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF											
Respiratory insufficiency											
Chronic obstructive pulmonary disease											
DUE TO, OR AS A CONSEQUENCE OF											
Acute or pulmonary											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES NO					
21a ACCIDENT WAS UNDERLYING			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year P.M. 19								
22a INJURY OCCURRED			22b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)			22c LOCATION Street or R.F.D. No. City or Town County State					
While at work Not while at work											
22a I certify that (I) (this hospital) attended the deceased from 8-21-68, 1968, to 1-1-69, 1969, that (I) (we) lost saw the deceased alive on 1-1-69, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE			22c DATE SIGNED			22d PHYSICIAN'S NAME (Type)			22e ADDRESS		
Rafael Marin-Aranda			11/1/68			RAFAEL MARIN-ARANDA			SPRING GROVE STATE HOSPITAL Baltimore, Md. 21228		
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			1-4-69			Charlestown Cemetery			Charlestown Cecil, Md.		
24. FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
Ralph E. Beck			JAN 9 1969			Rafael Marin-Aranda					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 151  
45M

MIDDLE									
<div style="display: flex; justify-content: space-between;"> <div> <p>1. DECEASED-NAME (Type or print) <b>Eleanor</b></p> <p>3 SEX <b>FEMALE</b></p> <p>7a BIRTHPLACE (State or foreign country) <b>Ohio</b></p> <p>10 CITY OR TOWN OF DEATH <b>TOWSON</b></p> <p>13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE <b>Maryland</b></p> <p>14. FATHER'S NAME First <b>Edward</b> Middle <b>S. Burnham</b> Last <b>?</b></p> <p>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b></p> </div> <div> <p>Middle <b>B.</b></p> <p>2a. DATE OF DEATH Month <b>1</b> Day <b>29</b> Year <b>69</b></p> <p>4 RACE <b>WHITE</b></p> <p>5. DATE OF BIRTH <b>4-4-1878</b></p> <p>6. AGE (In years last birthday) <b>90</b></p> <p>7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p> <p>8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>9. COUNTY OF DEATH <b>BALTIMORE</b></p> <p>11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <b>CHESAPEAKE MANOR</b></p> <p>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Homemaker</b></p> <p>12b KIND OF BUSINESS OR INDUSTRY <b>home</b></p> <p>13b COUNTY <b>Baltimore</b></p> <p>13c CITY OR TOWN <b>Phoenix</b></p> <p>13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>13e. STREET AND NUMBER <b>Cooper Road</b></p> <p>15 MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>?</b> Last <b>Loomis</b></p> <p>16b SOCIAL SECURITY NO. <b>220-05-0822D</b></p> <p>17 INFORMANT <b>Philip H. Cooper, Same as # 13</b></p> </div> </div>									
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b></p> <p><b>2014</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>Cerebral embolism</b></p> <p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)</p>									
<p>19a. DATE OF OPERATION</p> <p>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>									
<p>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. cert. examiner)</p> <p>21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b></p> <p>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</p> <p>21d. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</p> <p>21e. LOCATION Street or R.F.D. No. City or Town County State</p>									
<p>22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>									
<p>22b. SIGNATURE <b>Henry Fox Conkle MD</b> DEGREE <b>MD</b> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/></p> <p>22c. DATE SIGNED <b>1/29/69</b></p> <p>22d. PHYSICIAN'S NAME (Type) _____ 22e. ADDRESS _____</p>									
<p>23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b></p> <p>23b. DATE <b>1-31-1969</b></p> <p>23c. NAME OF CEMETERY OR CREMATORY <b>St. James, My Ladys Manor</b></p> <p>23d. LOCATION (City or Town) (County) (State) <b>Monkton, Maryland</b></p>									
<p>24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland</b></p> <p>25a. REC'D BY REG. STRAR <b>JAN 30 1969</b></p> <p>25b. REGISTRAR'S SIGNATURE <b>[Signature]</b></p>									



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-2, page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) <u>George A. Coupling</u>			First Middle Last			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> 1-17 1969			2b HOUR 12 M		
3 SEX <u>M</u>		4 RACE <u>W</u>		5 DATE OF BIRTH <u>8-31-1895</u>		6 AGE (in years last birthday) <u>73</u> YRS		7 MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN.		2c DATE PRONOUNCED DEAD <u>Jan 17</u> 19 <u>69</u>	
7a BIRTHPLACE (State or foreign country) <u>White Marsh Md.</u>				7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Chase Balto. County Md</u>		2d HOUR <u>130</u> P.M.	
10 CITY OR TOWN OF DEATH <u>Chase</u>				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>RETIRED</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <u>Md.</u>				13b COUNTY <u>Chase</u>		13c CITY OR TOWN <u>Chase</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <u>EASTERN AVE. + Marshy Pt.</u>	
14 FATHER'S NAME <u>Anderson Coupling</u>				First Middle Last		15 MOTHER'S M A DEN NAME <u>UNKNOWN</u>				First Middle Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <u>YES</u>				16b SOCIAL SECURITY NO. <u>WW#1</u>		17 INFORMANT <u>Audrey Coupling Cooper</u>				ADDRESS <u>EASTERN AVE. Marshy Pt.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>H-S + Hypertension. C.V. Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year <u>19</u> P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>M.B. Davis</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED <u>1/21/69</u>			
EXAMINER'S NAME (Type) <u>M.B. Davis M.D. - Dundalk</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City, Town, or County)			
23a BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b DATE <u>1-21-1969</u>		23c NAME OF CEMETERY OR CREMATORY <u>Sharp Street Cem.</u>		23d LOCATION (City or Town) <u>Chase</u>		(County)		(State)	
24 FUNERAL DIRECTOR <u>William E. Edickson</u>				ADDRESS <u>1129 h. Caroline</u>				25a REC'D BY REGISTRAR <u>JAN 27 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

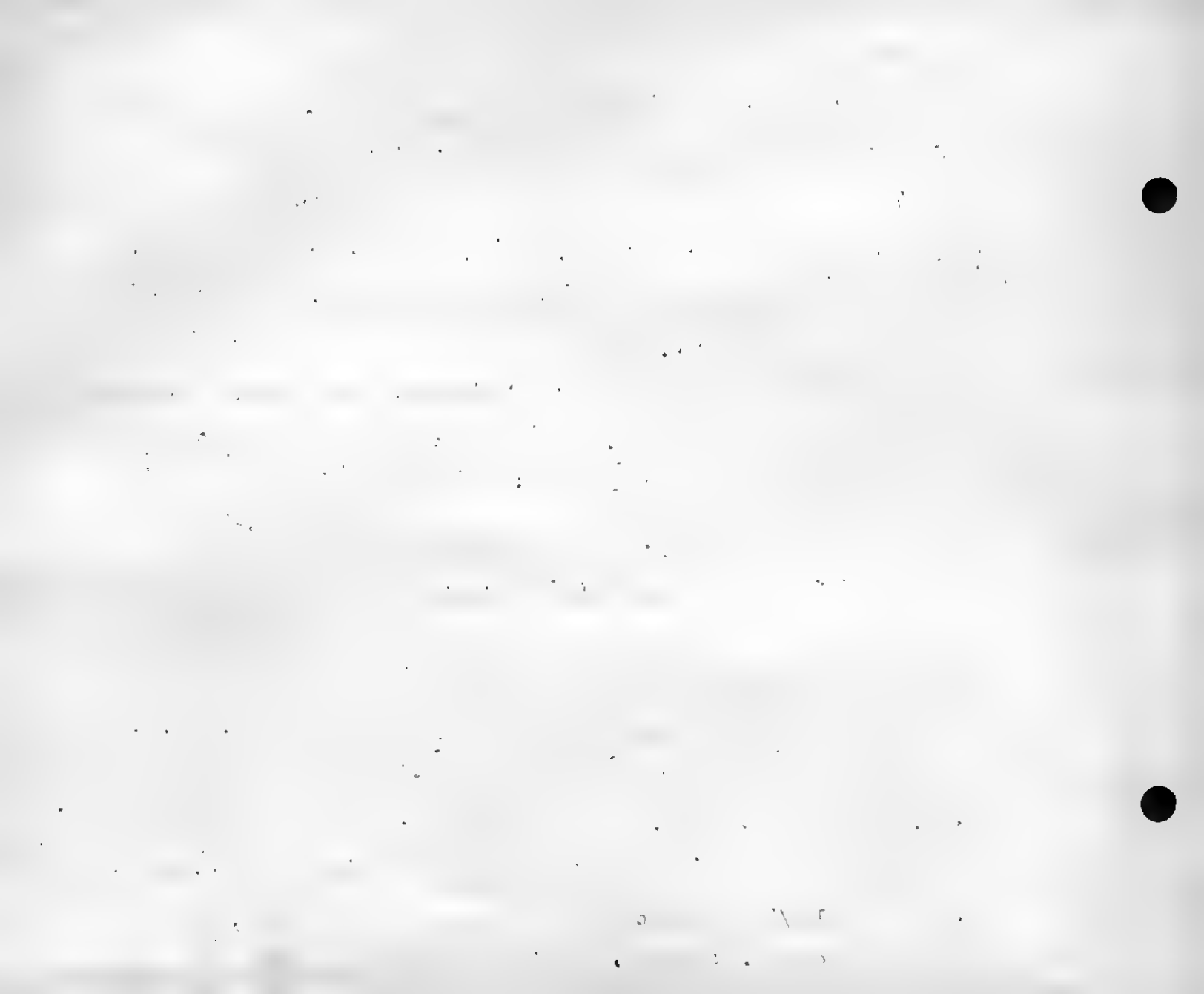


CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Thomas</b>		First <b>B</b>		Middle <b>Craig</b>		Last		2a. DATE OF DEATH Month <b>Jan</b> Day <b>4</b> Year <b>1969</b>		2b. HOUR <b>3:15 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH <b>Dec 5 1885</b>		6. AGE (In years last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS <b>13</b> DAYS <b>13</b>		IF UNDER 24 HRS HOURS <b>3</b> MIN <b>15</b>	
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTO</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CITIZENS HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) <b>CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>POSTELINE</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD</b> COUNTY <b>1</b>		13b. CITY OR TOWN <b>BALTO</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4305 WALTER AVE.</b>					
14. FATHER'S NAME <b>JAMES</b>		First <b>CRAIG</b>		Middle		Last		15. MOTHER'S MAIDEN NAME <b>JULIA A. COOKE</b>		First <b>COOKE</b> Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>216-01-2490</b>		17. INFORMANT <b>JEANNE C BRIDGES</b>		Address <b>Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>441.2 Atherosclerosis of Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>arterio + chronic failure of AF</b> (b) <b>atherosclerosis of coronary arteries</b> DUE TO, OR AS A CONSEQUENCE OF <b>atherosclerosis</b> (c) <b>3. Encephalopathy aneurysm</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>gentle atherosclerosis</b>											
19a. DATE OF OPERATION <b>1/7/69</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>10</b> P.M. <b>19</b> Month <b>Jan</b> Day <b>4</b> Year <b>1969</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from <b>July 15, 1967</b> to <b>Jan 4, 1969</b> , that (I) (we) last saw the deceased alive on <b>Dec 30 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>DONALD W. MINTZ</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Jan 4/69</b>					
22d. PHYSICIAN'S NAME (Type) <b>DONALD W. MINTZ</b>		22e. ADDRESS <b>3009 EVERGREEN AVE</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/7/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JAN 6 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Jones</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



7 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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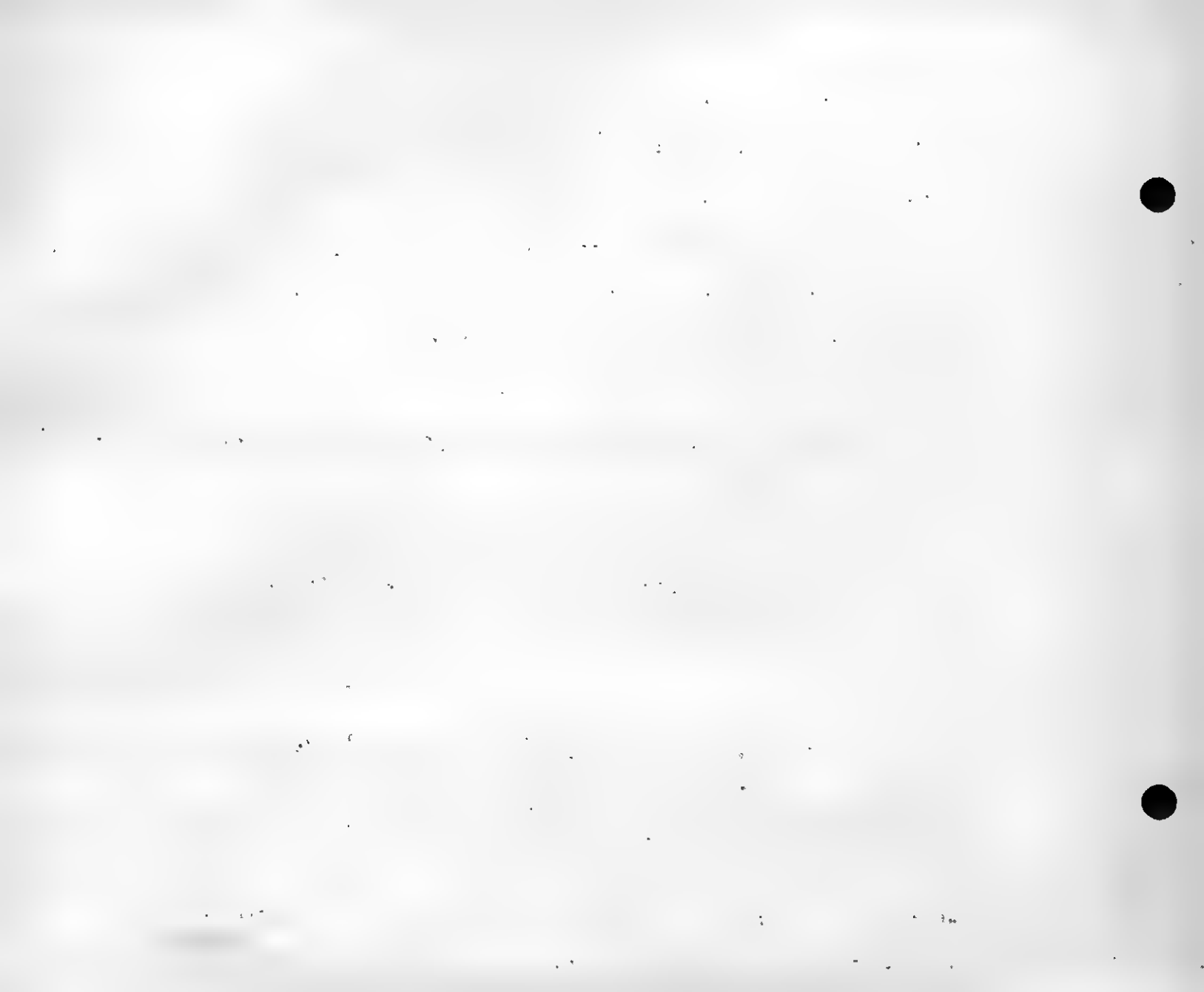
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00340

00336

1. DECEASED NAME (Type or print) <b>Marjorie Ann Crane</b>		First Middle Last		2a. DATE OF DEATH <b>1-12-1969</b>		2b. HOUR M	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>6-19-1928</b>		6. AGE (in years last birthday) <b>40</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1802 Leadburn Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Writer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME <b>Robert Davis Elliott</b>		First Middle Last		15. MOTHER'S M.A.DEN NAME <b>Margaret Ann Kotz</b>		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>365-28-1385</b>		17. INFORMANT <b>Stephen E. Crane</b>		Address <b>1802 Leadburn Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>metastatic carcinoma, origin unknown</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic glomerulonephritis with uremia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 1, 1968</b> to <b>January 12, 1969</b> , that (I) (we) lost saw the deceased alive on <b>Jan. 7, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>L. Myrton Leines Jr.</b>				22c. DATE SIGNED <b>Jan. 13, 1969</b>		22d. PHYSICIAN'S NAME (Type)	
22e. ADDRESS				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1-14-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 14 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

0034

CERTIFICATE OF DEATH

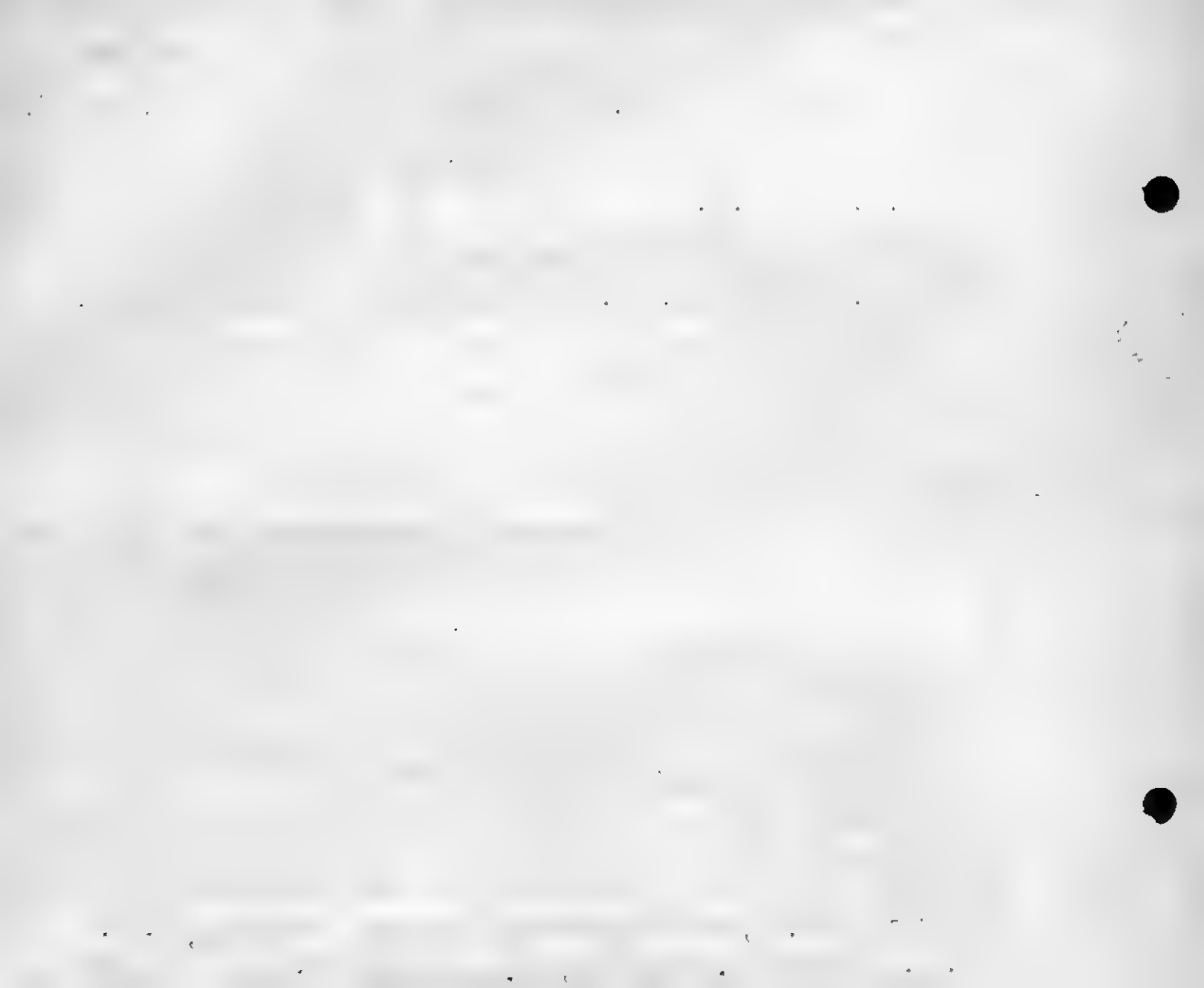
00337

1. DECEASED-NAME (Type or print) <b>MARGUERITE A. CROWE</b>			First Middle Last			2a. DATE OF DEATH <b>JAN, 21, 1969</b> Month Day Year			2b. HOUR M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 10, 1992</b>			6. AGE (In years last birthday) <b>76</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County</b> Md						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>9928 Harford Road</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>at home</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>9928 Harford Road</b>			
14. FATHER'S NAME <b>Thomas Crump</b> First Middle Last						15. MOTHER'S MAIDEN NAME <b>Teresa Heilmann</b> First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT <b>Family records</b> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of abdominal</b> <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>?</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>20 Sept</b> , 19 <b>64</b> , to <b>21 Jan</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>21 Jan</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Howard Goodman</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>23 Jan 69</b>						
22d. PHYSICIAN'S NAME (Type) <b>Howard Goodman</b>				22e. ADDRESS <b>8604 Harford Road</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 25 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>				23d. LOCATION (City or Town) (County) (State) <b>Balto. County, MD.</b>				
24. FUNERAL DIRECTOR <b>C. F. EVANS &amp; SON 8802 Harford Rd.</b>				25a. RECD BY REGISTRAR DATE <b>JAN 27 1969</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



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TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
0034									
00338									
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR	
William HENRY Dailey						Month Day Year January 11, 1969		2:20 PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
male		white		Jan. 31, 1889		79 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
D. C.		U. S.				Baltimore		Md	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville			SPRING GROVE STATE HOSP.			laborer			
13a U.S.A. RESIDENCE (Where deceased lived or admission) STATE			13b CITY OR TOWN		13c INSIDE CITY, IN TS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13a STREET AND NUMBER		
Md.			Pr. Geo.		Riverdale		5806 Longfellow St.		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Samuel H. DAILEY			Alice SWEENEY						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT Address				
			578-03-1675A		Records: SPRING GROVE STATE HOSPITAL				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary pneumonia and an</i>									
4124 DUE TO, OR AS A CONSEQUENCE OF <i>acute heart failure.</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>arteriosclerotic cardiovascular disease</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>multiple aneurysmal accidents (strokes)</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (X) (this hospital) attended the deceased from Feb. 16, 1968, to Jan. 11, 1969, that (I) (we) last saw the deceased alive on Jan. 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c DATE SIGNED							
<i>Dr. Rafael H. Marin</i>		1/14/69							
22d PHYSICIAN'S NAME (Type)		22e ADDRESS							
DR. RAFAEL H. MARIN		SPRING GROVE STATE HOSPITAL		Baltimore, Maryland 21228					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Jan. 17, 1969		Congressional Cemetery Washington, D. C.					
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
W. W. CHAMBERS CO. Riverdale, Md.		JAN 20 1969		<i>Charles Judge</i>					



## CERTIFICATE OF DEATH

00339

1 DECEASED NAME (Type or print) <b>WILLIAM LORING DAILEY</b>			2a. DATE OF DEATH Month <b>11</b> Day <b>11</b> Year <b>69</b>			2b. HOUR <b>9:30</b> PM	
3 SEX <b>MALE</b>		4 RACE <b>CAU</b>		5 DATE OF BIRTH <b>5/5/1910</b>		6 AGE (In years lost birthday) <b>58</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT. BALT. MED. CENT.</b>		12a. USUAL OCCUPATION (Kind of work done during most of life, even if retired) <b>Florist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Flower</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <b>Baltimore</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>6009 Altamont Place</b>							
14. FATHER'S NAME First Middle Last <b>David M. Dailey</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Dora Masemore</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) <b>no</b>		16b. SOCIAL SECURITY NO <b>216-09-8474</b>		17. INFORMANT Address <b>Edith S. Dailey 6009 Altamont Place</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRONCHOPNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONJESTIVE HEART FAILURE/EMPHYSEMA</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs.</b> <b>3 wks</b> <b>2 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> , 19 <b>69</b> , to <b>1/11</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1/11</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Malcolm C. Sheppard</i>		DEGREE <b>MD</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/11/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>MALCOLM C. SHEPPARD</b>		22e. ADDRESS <b>6701 N CHARLES ST BALT, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE <b>1-15-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove Methodist</b>		23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson</b>				ADDRESS <b>1050 York Rd. 21204</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 14 1969</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15  
30M REV. 1-65

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>ANNIE RUTH DAVIS</b>			2a. DATE OF DEATH <b>January 2, 1969</b>			2b. HOUR <b>9:15 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>June 7, 1874</b>		6. AGE (In years birthday) <b>94</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore, Md.</b>			
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8005 Oakleigh Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before adm. ssion) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8005 Oakleigh Road</b>	
14. FATHER'S NAME First Middle Last <b>Andrew Jackson Brown</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Sarah E. Peters</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>220-54-7739</b>		17. INFORMANT Address <b>Mrs. Fred. Ruff 8005 Oakleigh Rd. Balt. Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>last</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>10 yrs +</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan, 1969</u> , to <u>Jan, 1969</u> ; that (I) (we) last saw the deceased alive on <u>12/17/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>E. Harris</u> MD. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>1/2/69</b>					
22d. PHYSICIAN'S NAME (Type) <b>Dr. S. Elliott Harris M.D.</b>				22e. ADDRESS <b>8100 Harford Road, Parkville, Balt. Co. Md.</b>					
23a. BURIAL, CREMATION, ETC. (Type) <b>Burial</b>		23b. DATE <b>1-4-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Monocacy Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Beallsville, Montgomery, Md.</b>			
24. FUNERAL DIRECTOR <u>Robert E. Dailey &amp; Son</u> ADDRESS <b>Frederick, Maryland</b>				25a. REG. NO. <b>1969</b> REGISTRAR <u>George</u>		DATE			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
OLIVIA K. DAVIS						1 28 69			10 P M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
F		W		6-27-1882			86 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Balt		USA				Baltimore Co Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			PickersGill Receptionist			Store					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md					CITY				3333 N CHARLES		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John Christopher											Seibert
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			217-20-3920			Doris Shuman			615 Chestnut Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.S.C.U.D</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>11.30</u> , 19 <u>64</u> , to <u>1.28</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1.27</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Margaret E. Day MD</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>January 29, 1969</u>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS <u>H-E-33rd St Balto Md 21218</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 31, 1969		Prospect H. II				York, Penna.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm Cook Brooks Towson		Towson Md		JAN 30 1969		Blanche Judge					



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VR 115-1  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <b>Laura W. DeBullett</b>			2a. DATE OF DEATH 1 Month 14 Day 69 Year			2b. HOUR 6:00 P.M.			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH 7/25/1881		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTO.</b>			
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>17 FUSTING AVE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>17 FUSTING AVE.</b>	
14. FATHER'S NAME <b>BENJAMIN</b>		14. FATHER'S NAME <b>Whiteley</b>		15. MOTHER'S MAIDEN NAME <b>Rebecca</b>		15. MOTHER'S MAIDEN NAME <b>BOSERMAN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. (If you give war or dates of service)		17. INFORMANT <b>MRS. CARL M. KOCHIG</b>		Address <b>17 FUSTING AVE.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4124</b> <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs +</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 4</b> , 19 <b>56</b> , to <b>Jan.</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-9</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John A. Nesbitt, Jr., M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1-15-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>John A. Nesbitt, Jr., M.D.</b>				22e. ADDRESS <b>1009 Frederick Road</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>11/17/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LONDON PK</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. Md.</b>			
24. FUNERAL DIRECTOR <b>E. S. Mac Nabb</b>				ADDRESS <b>301 Frederick Rd Balto 28 Md</b>		25a. REC'D BY REGISTRAR <b>JAN 20 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>LILLIAN</b>		First	Middle	Last	2a. DATE OF DEATH Month <b>January</b> Day <b>23</b> Year <b>1969</b>	2b. HOUR M
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>9-13-1883</b>		6. AGE (In years last birthday) <b>85</b> YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Balto., Md</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Sparrow Point, Baltimore Md</b>		
10. CITY OR TOWN OF DEATH <b>Dundalk</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>719 I Street</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Md</b>	13b. COUNTY <b>Dundalk</b>	13c. CITY OR TOWN <b>Dundalk</b>	13d. INSIDE CITY, J.M.S? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>719 I Street</b>		
14. FATHER'S NAME First <b>Irvin</b> Middle <b>Cornish</b> Last <b>Sarah</b>		15. MOTHER'S MAIDEN NAME First <b>Sarah</b> Middle <b>Milburn</b> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No.</b> (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>137-14-3385</b>		17. INFORMANT Address <b>Mrs. Mamie Turner 719 I Street</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 HRS</b> <b>20 YRS</b>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1-5</b> , 19 <b>69</b> , to <b>Jan 23</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1-5</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>John V. Conway, M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1-27-69</b>
22d. PHYSICIAN'S NAME (Type) <b>John V. Conway, M.D.</b>		22e. ADDRESS <b>914 D ST. BALTO, MD 21219</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-28-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>A.A. Co., Maryland</b>
24. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT F.H. 1701 Laurens St.</b>				25a. REC'D BY REGISTRAR <b>JAN 28 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>



## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) CHARLES H. DEISE, SR.			2a. DATE OF DEATH Jan. 11, 1969			2b. HOUR M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 31, 1900		6. AGE (In years last birthday) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9501 Harford Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Real Estate		12b. KIND OF BUSINESS OR INDUSTRY self-employed					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 9501 Harford Road					
14. FATHER'S NAME First Middle Last John Deise				15. MOTHER'S MAIDEN NAME First Middle Last Margaret Winters							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no				16b. SOCIAL SECURITY NO 212 22 6198		17. INFORMANT family records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Circulatory Collapse / Asphyxia 1 X 5 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic carcinoma 6-7 yr. DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma Prostate 1-8 yr. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) hip fracture pathologist repaired 6 mos old										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. - Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work or work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1969, to Jan. 11, 1969, that (I) (we) last saw the deceased alive on Jan. 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Frank T. Kasik, Jr.				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/13/69			
22d. PHYSICIAN'S NAME (Type) Frank T. Kasik, Jr.				22e. ADDRESS 9005 Harford Rd. Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 1/14/69		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Balto. County, Md.					
24. FUNERAL DIRECTOR C. F. EVANS & SON, INC. 8802 Harford Rd.				ADDRESS		25a. REGISTRY BY REGISTRAR JAN 15 1969		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

0034

06345

1. DECEASED NAME (Type or print) First Middle Last Mildred Eva DENBOW			2a. DATE OF DEATH Month Day Year 1 1 25 69		2b. HOUR 7 a.m.
3. SEX female	4. RACE white	5. DATE OF BIRTH 1/4/16		6. AGE (In years last birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Delaware	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balt. Med. Center	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Tavern Owner		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3308 Woodstock Ave	
14. FATHER'S NAME First Middle Last Benjamin Wnuk	15. MOTHER'S MAIDEN NAME First Middle Last Veronica ?				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-09-6043	17. INFORMANT Address Mrs Carolyn Gatewood 1324 Kenton Rd			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the ovary</u> 1830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan. 14, 1969, to Jan. 25, 1969, that (I) (we) last saw the deceased alive on Jan. 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John E. Adams				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED Jan. 25, 1969
22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D.				22e. ADDRESS 6701 N. Charles St., Balto. Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/29/69	23c. NAME OF CEMETERY OR CREMATORY Mt Zion		23d. LOCATION (City or Town) (County) (State) Harford County Maryland	
24. FUNERAL DIRECTOR E.J. ROCK		ADDRESS 5305 Harford Road		25a. REC'D BY REGISTRAR DATE JAN 27 1969	25b. REGISTRAR'S SIGNATURE Charles Judge

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VR 45M

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
FRED					DENNIS	Month Day Year JANUARY 3, 1969			12:30 PM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years lost birthday)		7 IF UNDER 1 YEAR	
MALE		NEGROID		MAY 8, 1926		42 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
VIRGINIA		U.S.A.				BALTIMORE Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		VETERANS ADMINISTRATION		MAINTENANCE MAN					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3e. STREET AND NUMBER
MARYLAND					BALTIMORE				1644 MONUMENT STREET
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S M A D E N NAME			First Middle Last
NORVAL					DENNIS	BRITTANIA			JONES
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		7 INFORMANT Address				
YES			WW II		228 22 4677 CLINICAL RECORDS, VA HOSP, FT HOWARD, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE									DAYS
4309 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <del>XX</del> (this hospital) attended the deceased from 12-26-68, 19__, to 1-3-69, 19__, that <del>XX</del> (we) last saw the deceased alive on 1-3-69, 19__, and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>XX</del> (we) (d.d) <del>XXXX</del> view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Madhav D. Barhanpurkar						1-4-69			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
MADHAV D. BARHANPURKAR, M.D.						VA HOSPITAL, FT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		1-7-69		Balt. Nat'l Cem.		Baltimore Md			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
MORTON & DYETT FUNERAL HOME, AVONDALE RD, BALTO, MD						JAN 6 1969		Charles Jones	



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30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

30351

00347

1. DECEASED-NAME (Type or print) <b>PAUL JOSEPH DIGNAZIO</b>			2a. DATE OF DEATH Month <b>January</b> Day <b>2</b> Year <b>1969</b>			2b. HOUR <b>8:10</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>September 28, 1918</b>		6. AGE (In years last birthday) <b>50</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>	
10. CITY OR TOWN OF DEATH <b>Eastpoint</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7929 Lansdale Rd., #24</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Book-keeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Co.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Eastpoint</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <b>Angelo</b> Middle <b>Dignazio</b> Last <b>Dignazio</b>		15. MOTHER'S MAIDEN NAME First <b>Rachael</b> Middle <b>Amato</b> Last <b>Amato</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. <b>215-05-6374</b>		17. INFORMANT Address <b>Sara T. Dignazio 7929 Lansdale Rd., #24.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolus</b> <b>18X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Rheumatic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-1-69</b> , 19 <b>69</b> , to <b>1-2-69</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12-20-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John Costantini, M.D.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1-3-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>JOHN COSTANTINI</b>				22e. ADDRESS <b>234 S. Conkling St., Balto., 21224, Md.</b>			
23a. BURIAL CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>1-6-69.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>7225 Eastern Blvd., Ba. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Charles S. Geiler</b>		6224 Eastern Ave. <b>Balto., 21224, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 7 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Robert S. Judge</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First <b>WILLIAM</b>		Middle <b>HENRY</b>		Last <b>DOBSON</b>		2a. DATE OF DEATH Month Day Year <b>JANUARY 14, 1969</b>		2b. HOUR <b>4:30A</b>
3. SEX <b>MALE</b>		4. RACE <b>NEGROID</b>		5. DATE OF BIRTH <b>9 17 28</b>		6. AGE (in years last birthday) <b>40</b> YRS		7. IF UNDER YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>					
10. CITY OR TOWN OF DEATH <b>FT HOWARD</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOSPITAL VETERANS ADMINISTRATION</b>			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <b>JANITOR</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>TALBOT</b>		13c. CITY OR TOWN <b>EASTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>106 TALBOT LANE</b>		
14. FATHER'S NAME First Middle Last <b>HARRY M DOBSON</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>DAISY JENKINS</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>YES</b>			16b. SOCIAL SECURITY NO <b>220 20 9040</b>		17. INFORMANT Address <b>CLINICAL RECORDS, VA HOSP, FT HOWARD, MD</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SPONTANEOUS PNEUMOTHORAX, BILATERAL</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PULMONARY EMPHYSEMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b>  <b>YEARS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>CEREBROVASCULAR ACCIDENT</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No autopsy</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No		City or Town		County		State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12 9 68</b> , 19____, to <b>1 14 69</b> , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1 14 69</b> , 19____, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE <i>Erhard J. Bunyor</i>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1 14 69</b>					
22d. PHYSICIAN'S NAME (Type) <b>ERHARD J. BUNYOR, M.D.</b>		22e. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1/18/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RICHARDSON CEMETERY</b>				23d. LOCATION (City or Town) (County) (State) <b>EASTON, MARYLAND</b>			
24. FUNERAL DIRECTOR <i>Barbara L. Dashiell</i>		ADDRESS <b>106 Talbot St. Easton, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 16 1969</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print)			First Florence			Middle E.			Last Dodd			2a. DATE KNOWN OF DEATH ESTIMATED January 21 1969	2b. HOUR 12:00 PM		
3. SEX Female	4. RACE Cau.	5. DATE OF BIRTH 10-20-1890	6. AGE (In years last birthday) 78 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD January 21 1969	7d. HOUR 12:00 PM									
7a. BIRTHPLACE (State or foreign country) Va.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore						
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's			12a. USUAL OCCUPATION (Kind at work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Rossville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Box 406 Babikow Rd. 6			
14. FATHER'S NAME First Puttman				Middle Worell				15. MOTHER'S MAIDEN NAME First Rajuill				Middle Worell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO 228-50-2455				17. INFORMANT ADDRESS Conrad Bartenfelder Box 406 Babikow Road 6			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												3 Days			
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) Generalized Arteriosclerosis												10+ yrs			
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 12:00 PM 1/18/69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fell on Floor							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No City or Town County State Box 406 Babikow Rd.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS. STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) 22b. DATE SIGNED 1/21/69											
23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE 1-24-1969				23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery				23d. LOCATION (City or Town) (County) (State) Oak Grove Va.			
24. FUNERAL DIRECTOR ADDRESS Laosha Funeral Home 2401 Bel Air Road				25a. REC'D BY REGISTRAR DATE JAN 23 1969				25b. REGISTRAR'S SIGNATURE [Signature]							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year	
Elizabeth			W.		Donaldson				JANUARY 31 1969	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		2b HOUR	
Female		White		4-12-1895			73 YRS.		2 P.M.	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Alabama		USA				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson			Chesapeake Manor N.H.			Housewife		Own Home		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.			N		Baltimore				4020 Roland Ave.	
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Joseph			J.		Willet				Melanie Wood	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17 INFORMANT		Address			
No			133-05-801		Mrs. Harry C. Thompson		New Orleans La			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. Pyelonephritis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>FATTY DEGENERATION OF LIVER</u>										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
21a INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		Street or R.F.D. No		City or Town		
22a. I certify that (I) (this hospital) attended the deceased from <u>AUGUST</u> , 19 <u>50</u> , to <u>JAN 31</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>JAN 26</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE		M.D., DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED				
<u>John M. Scott</u>						1/31/69				
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS		22f						
JOHN M. SCOTT		600 W. BELVEDERE AVE., BALTIMORE		21210						
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		2-3-69		Grace Episcopal		Elkridge Howard		Md.		
24. FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
H.W. Jenkins & Sons Co. 4905 York Rd.				FEB 4 1969		John J. Jones				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers, (ages) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

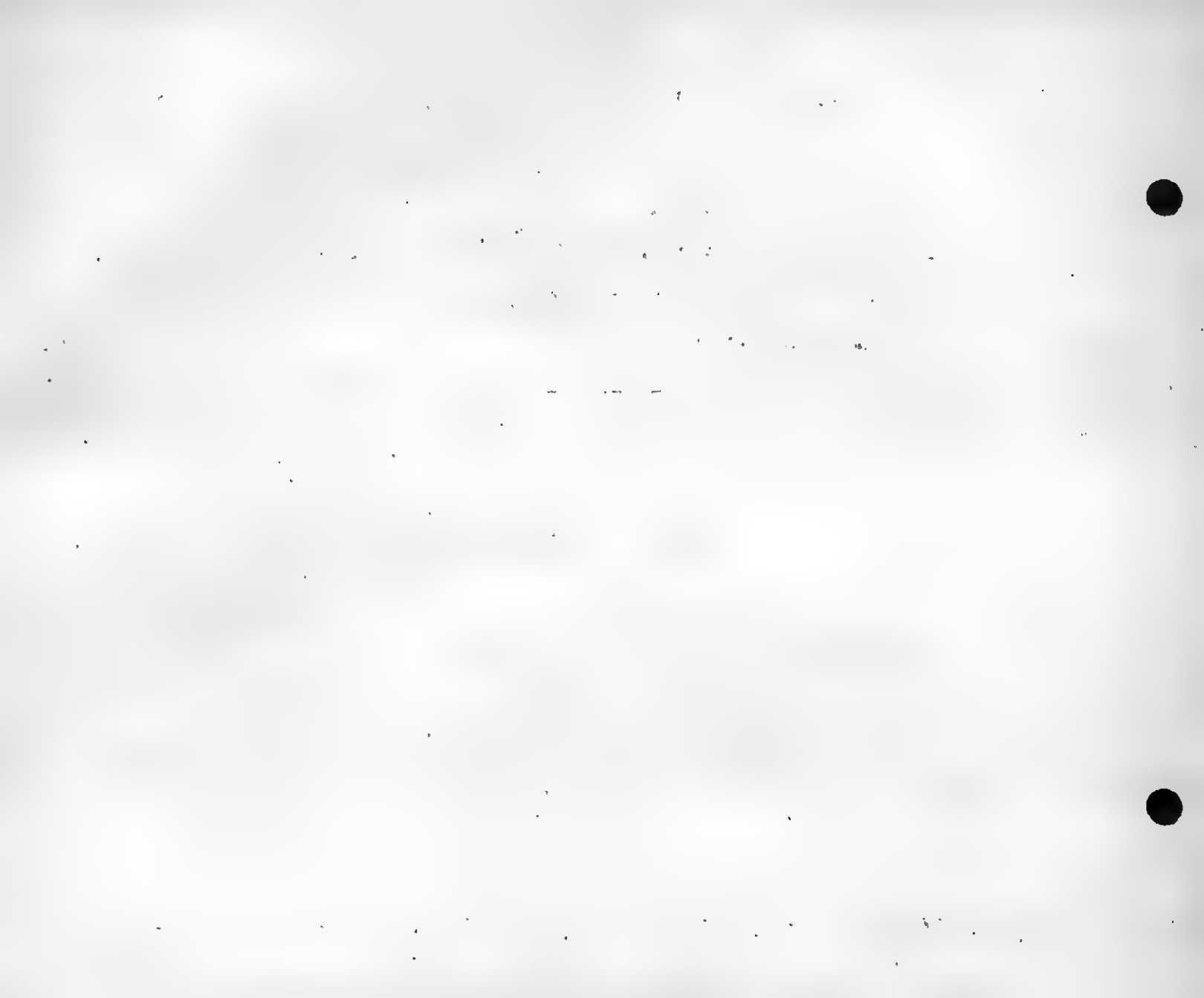
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
BERNARD J. DONIECKI, SR.						January Month 3, Day 1969		M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
Male		White		12-10-1881		87 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Poland		U.S.A.				Baltimore Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Lansdowne			322 First Avenue			Retired Foreman				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Lansdowne		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		322 First Avenue	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
Conrad Doniecki					Frances Ostrowski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No			705-09-0113		Mrs. Genevieve F. Debus, 618 Washington Ave. 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>metastatic Ca of lungs</i>									6. mo	
1621 DUE TO, OR AS A CONSEQUENCE OF (b)										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov</i> , 1968, to <i>1/2</i> , 1969, that (I) (we) lost saw the deceased alive on <i>1/2</i> 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Dr. John Pound MD</i>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>1/3/69</i>			
22d. PHYSICIAN'S NAME (Type) Dr. John Pound					22e. ADDRESS 3325 Frederick Ave., Balto., Md.					
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		1-6-1969		Holy Rosary Cemetery		German Hill Rd. Balto., Md.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Howard H. Hubbard, 4107 Wilkens Ave. 21229					DATE JAN 6 1969		<i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item#13eFilm#G408 1/22/69 vmp <b>CERTIFICATE OF DEATH</b> 00352											
1 DECEASED-NAME (Type or print) First <b>Eliza</b> Middle <b>Florence</b> Last <b>Dorman</b>						2a. DATE OF DEATH Month <b>1</b> Day <b>16</b> Year <b>69</b>			2b. HOUR <b>6:50</b> <sup>PM</sup>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>3/9/73</b>		6. AGE (In years lost birthday) <b>95</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Baltimore</b> Md					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Augsburg Home 6811 Campfield Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Dressmaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Store</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Cockeysv'1</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>none</b>			
14 FATHER'S NAME First <b>James H.</b> Middle <b>Dorman</b> Last				15 MOTHER'S MAIDEN NAME First <b>Pope</b> Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO <b>216-07-4491-A</b>		17 INFORMANT <b>Walter H. Heller</b>		Address <b>6811 Campfield Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) <b>1) Influenza</b>											
DUE TO, OR AS A CONSEQUENCE OF <b>2) Arterio Sclerotic Heart</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>3) Senile Dementia</b>											
DUE TO, OR AS A CONSEQUENCE OF <b>4) Generalized Arterio Sclerosis</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
<b>Generalized Arterio Sclerosis</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>56</b> , to <b>July - 16</b> , 19 <b>69</b> , that (I) <del>was</del> last saw the deceased alive on <b>July - 9</b> , 19 <b>67</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <b>did</b> view the body after death.											
22b. SIGNATURE <b>Earl L. Chambers</b>				22c. DATE SIGNED <b>1/16/69</b>		22d. PHYSICIAN'S NAME (Type) <b>EARL L. CHAMBERS</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1/18/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>					
24. FUNERAL DIRECTOR <b>H. Beermann</b>		ADDRESS <b>6067 Harford Rd</b>		25a. REGD BY REGISTRAR <b>20</b> 1969		25b. REGISTRAR'S SIGNATURE <b>John Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1035

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10353

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>MARTIN DUBIN (DUBANSKY)</b>			2a. DATE OF DEATH Month Day Year <b>JANUARY 12, 1969</b>		2b. HOUR <b>12:05 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>MARCH 11, 1903</b>		6. AGE (In years last birthday) <b>65</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>BALTO. CO. GEN. HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>GROCCER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>STORE</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>APT. 202 7926 DUNHILL VILLAGE CIRCLE</b>
14. FATHER'S NAME First Middle Last <b>BERNARD DUBANSKY</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>LENA BECKER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-03-9641A</b>		17. INFORMANT Address <b>MRS. MINNIE DUBIN, 7926 DUNHILL VILLAGE CIRCLE APT. 202</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ASLD. acute coronary</b> DUE TO, OR AS A CONSEQUENCE OF <b>Surgical Cerebral Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <b>Heart Disease</b> (b) <b>Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1967</b> , to <b>1969</b> , that (I) (we) lost saw the deceased alive on <b>12-19-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <b>Leonard M. Lister</b>		22c. PHYSICIAN'S NAME (Type) <b>LEONARD M. LISTER</b>		22d. ADDRESS <b>7111 PARK HEIGHTS AVENUE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1-14-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OHR KNESSETH ISRAEL ANSHE</b>	
23d. LOCATION (City or Town) (County) (State) <b>SFARD, ROSEDALE, MARYLAND</b>		24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD</b>		25a. REC'D BY REGISTRAR <b>JAN 17 1969</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

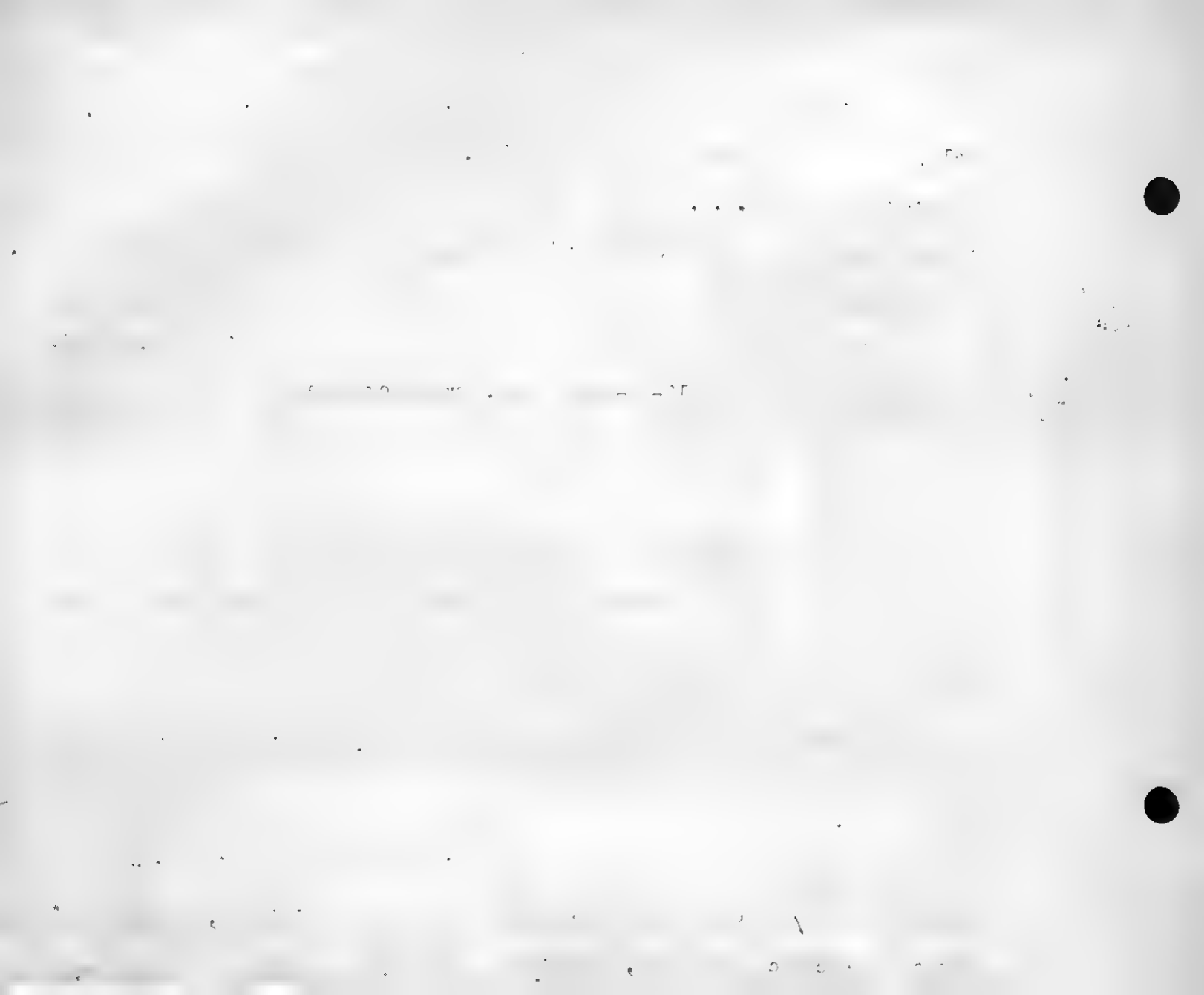
1 DECEASED NAME (Type or print) <b>Katherine</b>			First <b>H.</b>			Middle <b>Dudley</b>			Last			2a DATE OF DEATH Month <b>17</b> Day <b>69</b> Year			2b. HOUR <b>5:45PM</b>		
3 SEX <b>Female</b>			4 RACE <b>Cau.</b>			5. DATE OF BIRTH <b>January 17, 1910</b>			6. AGE (In years last birthday) <b>59</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>			7b CITIZEN OF WHAT COUNTRY? <b>USA</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Baltimore,</b>								
10 CITY OR TOWN OF DEATH <b>Baltimore, Md.</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greater Balto. Med. Center</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Clerical</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Pharm. Co.</b>								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b. CITY OR TOWN <b>Baltimore</b>			13c CITY OR TOWN <b>Towson</b>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER <b>332 Stanmore Rd. 21204</b>					
14. FATHER'S NAME <b>Chas. F. Dudley</b>			First <b>H.</b>			Middle <b>Dudley</b>			Last			15 MOTHER'S MAIDEN NAME <b>Katherine Fralinger</b>			First <b>H.</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>			16b. SOCIAL SECURITY NO <b>213-03-5539 H.A.</b>			17. INFORMANT <b>Mrs. Louise Thomas</b>			Address <b>332 Stanmore Rd. 04</b>								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>3740</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Mitral stenosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Rheumatic heart disease</b>															APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Focal acute bronchopneumonia</b>																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>1/8</b> , 19 <b>69</b> , to <b>1/17</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/17</b> , 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b SIGNATURE <b>Charles C. Brown, M.D.</b>			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>1/18/69</b>								
22d PHYSICIAN'S NAME (Type) <b>Charles C. Brown, M.D.</b>			22e. ADDRESS <b>Greater Baltimore Medical Center</b>														
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>1/21/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>			23d LOCATION (City or Town) (County) (State) <b>Balto.</b>								
24 FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home-6500 York Rd-21212</b>			25a. REC'D BY REGISTRAR <b>JAN 27 1969</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on page 1, funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 13 Film 409 1/29/69 kk											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <b>CHARLES C DUKE</b>				2a. DATE OF DEATH Month <b>Jan</b> Day <b>22</b> Year <b>1969</b>				2b. HOUR <b>5:30 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 10, 1886</b>				6. AGE (In years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>				Md	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St Joseph Nursing Home</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Clerk (retired)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hopkins Hosp.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. CITY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>135 N. Broadway</b>			
14. FATHER'S NAME First <b>John</b> Middle <b>F</b> Last <b>Duke</b>				15. MOTHER'S MAIDEN NAME First <b>?</b> Middle <b>?</b> Last <b>Nunthall</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-14-1832</b>		17. INFORMANT <b>Rev. Frederick Duke</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>1 Jan</b> , 19 <b>68</b> , to <b>22 Jan</b> , 19 <b>69</b> , that (I) (we) lost the deceased alive on <b>22 Jan</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William Goodman</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>22 Jan 69</b>					
22d. PHYSICIAN'S NAME (Type) <b>WILLIAM GOODMAN</b>				22e. ADDRESS <b>1534 Lutherdale Rd.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/25/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>				23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc Baltimore, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 23 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR
JOHN HENRY DURANT						January 31 1969			11: a.m.
3. SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR	
Male	Negro		October 14, 1910			38		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
South Carolina		U.S.A.				Baltimore			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INST. T.U. ON (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Fort Howard			Veterans Adm. Hospital			Truck Driver			Food Distributor
13a USUAL RESIDENCE (Where deceased admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland					Baltimore				04 N. Gilmore Street
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
ESLI			DURANT			BEATRICE HOLMES			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT Address			
Yes			WW-11			577 05 36 42 Clinical Recds VA Hospital, Fort Moward Md.			
18 CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG, LEFT									MONTHS
1621 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MULTIPLE METASTASIS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (X) (this hospital) attended the deceased from Sept 4, 1969, to Jan. 31, 1969, that (X) (we) last saw the deceased alive on Jan. 31, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
Sung Il Shin									2/1/69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
SUNG IL SHIN, M.D.					VA Hospital, Fort Moward, Maryland				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL		2/5/1969		BALTIMORE NATIONAL CEMETERY, BALTIMORE, MD.					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HAYES FUNERAL HOME				638 N. GILMORE ST. BALTO., MD.		FEB 3 1969		Charles Judge	



**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

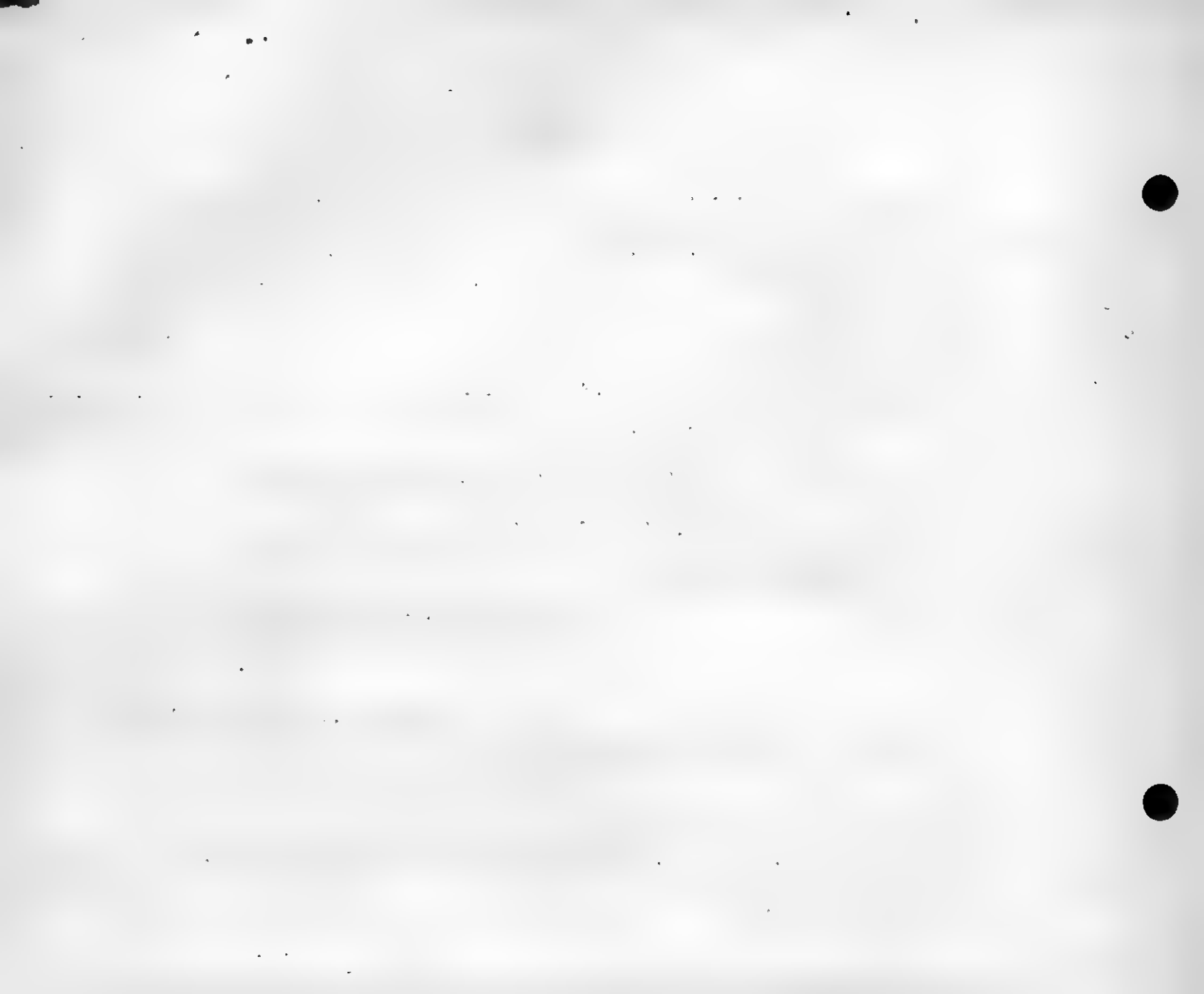
1036

00357

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First <b>JAMES</b>		Middle		Last <b>DUSEK</b>		2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> 1 Day 8 Year 1969		2b HOUR 6:30 A.M.	
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>9/28/93</b>	6 AGE (in years) 75 YRS	(IF UNDER 1 YEAR) MONTHS DAYS		(IF UNDER 24 HRS) HOURS MIN		2c DATE PRONOUNCED DEAD Month 1 Day 8 Year 1969		2d HOUR 6:30 A.M.	
7a BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>BALTIMORE COUNTY, Md</b>					
10 CITY OR TOWN OF DEATH <b>FORT HOWARD</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. AD. HOSPITAL</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>BAKER</b>			12b KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>MARYLAND</b> COUNTY <b>---</b>				13b CITY OR TOWN <b>BALTIMORE</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET AND NUMBER <b>2731 ASHLAND AVENUE</b>			
14 FATHER'S NAME First Middle Last <b>ANTON DUSEK</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>XXXXXXXXX JULIA SVOBODA</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		(If yes give war or dates of service) <b>WW I</b>		16b. SOCIAL SECURITY NO. <b>219 32 49 13</b>		17. INFORMANT ADDRESS <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONITIS</b> <b>804X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>FRACTURE OF LEFT FEMUR</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>42 days</b> <b>10 years</b> <b>72 days</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>PARKINSON'S DISEASE</b>											
19a. DATE OF OPERATION <b>10/30/68</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Open Reduction: Tracheostomy</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>10/28</b> 19 <b>68</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Fell out of bed at home.</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>		21f. LOCATION Street or R.F.D. No City or Town County State <b>2731 Ashland Ave., Baltimore, Maryland</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Melvin B. Davis</b>		EXAMINER'S NAME (Type) <b>MELVIN B. DAVIS, M.D., 6800 MORN INGTON RD, BALTIMORE, MD. 21222</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1/8/69</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1/10/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>JAN 13 1969</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
24. FUNERAL DIRECTOR <b>SCHULINUE FUNERAL HOME, 13 BREHNS LANE, BALTIMORE, MD.</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month <u>4</u> , Day <u>1969</u> Year		2b. HOUR <u>4:20</u> M	
WILLIAM M. EASLEY									
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1-27-1903		6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md.	
10. CITY OR TOWN OF DEATH Relay		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 815 Francis Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Relay		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 815 Francis Avenue	
14. FATHER'S NAME First Middle Last Thomas Easley			15. MOTHER'S MAIDEN NAME First Middle Last Anna Brenner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 705-09-8055		17 INFORMANT Address Mrs. Grace I. Easley, 815 Francis Ave. 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary occlusion</u> 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular</u> 2 mo (c) <u>diabetes</u> 20 yrs DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (1) (this hospital) attended the deceased from <u>Jan 7, 1969</u> , to <u>Jan 4, 1969</u> , that (1) (we) last saw the deceased alive on <u>Jan 3, 1969</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (I) (did not) view the body after death.									
22b. SIGNATURE <u>B. Brumbaugh</u> M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/4/69</u>			
22d. PHYSICIAN'S NAME (Type) Dr. Bruce Brumbaugh				22e. ADDRESS 5609 Main Street, Elkridge, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-7-1969		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park		23d. LOCATION (City or Town) (County) (State) Liberty Rd., Carroll County, Md			
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229				25a. RECEIVED BY REGISTRAR DATE JAN 6 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b HOUR	
BERTHA V. EDWARDS						Jan. 1. 1969		12.55	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
F		W		July 5 1889		79 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Balto. Co.		U. S. A.				Balto.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bengies						Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Balto.		Bengies				Edwards Rd.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Jacob Robertson			Matilda Campbell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give unit or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no					Alma Milke Rt. 14, Box 617 Balto. 21220				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Atherosclerosis</u> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly med cal examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 68</u> , 19 <u>68</u> , to <u>11/1/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>12/30/68</u> , 19 <u>68</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>		22c. DATE SIGNED 1/3/69		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 6402 Golden Bay Rd. 21237			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 1/4/69		23c. NAME OF CEMETERY OR CREMATORY Orem Cem.		23d. LOCATION (City or Town) (County) (State)			
Burial						Balto. Co. Md.			
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair RD. 21236				25a. REC'D BY REGISTRAR JAN 6 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

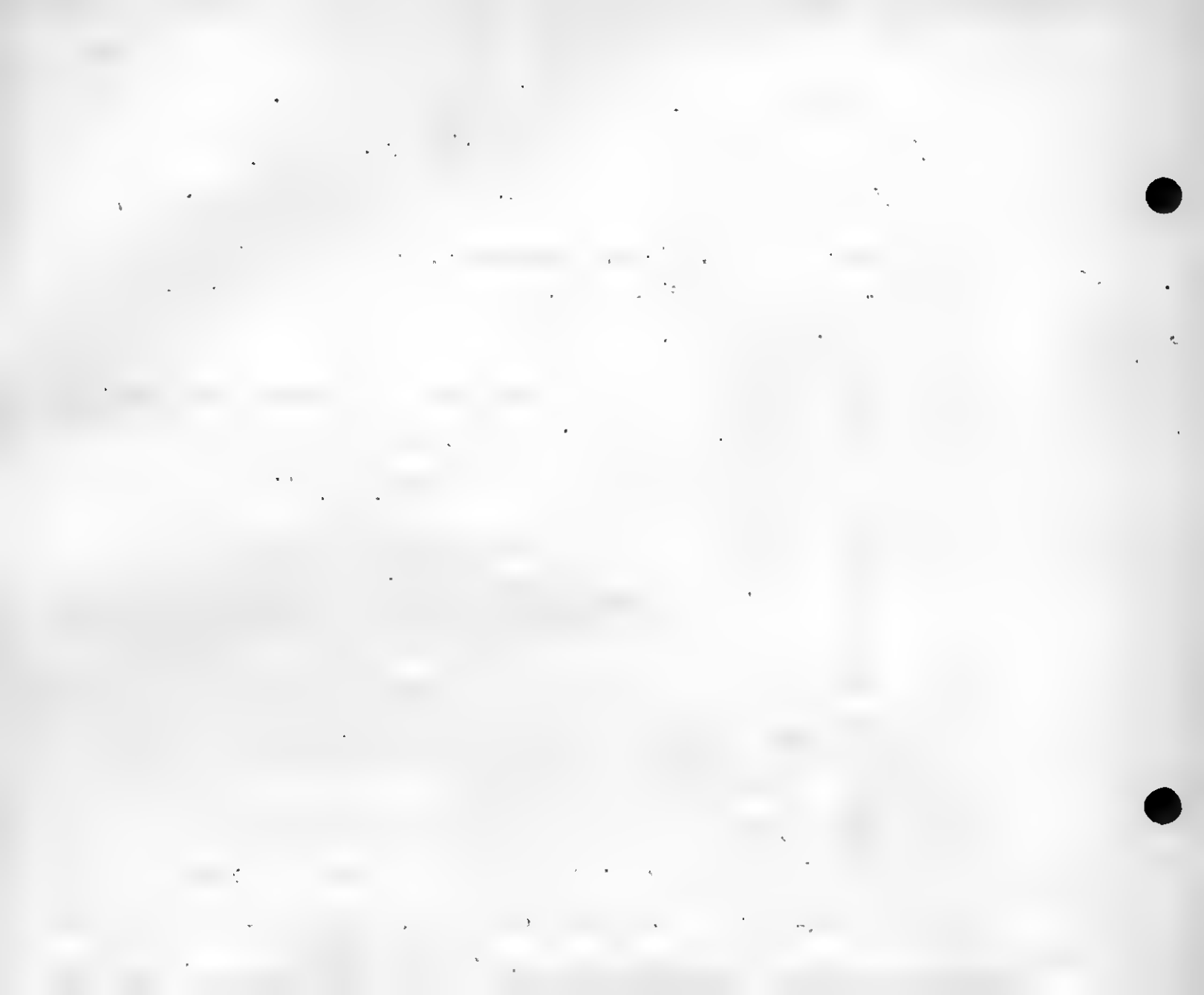
00364

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00360

1 DECEASED NAME (Type or print) <b>GLADYS E. EHRHARDT</b>			2a DATE OF DEATH Month <b>JAN</b> Day <b>11</b> Year <b>1969</b>		2b HOUR <b>7:45</b> AM
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>2/2/95</b>		6. AGE (In years last birthday) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>N J</b>	7b. CITIZEN OF WHAT COUNTRY? <b>US</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Baltimore County, Md.</b>		
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson State Hosp.</b>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>	13b COUNTY <b>HARFORD</b>	13c CITY OR TOWN <b>ABERDEEN</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>QTRS 15 ABERDEEN PROGR.</b>	
14. FATHER'S NAME First <b>JAMES T</b> Middle <b>VAN</b> Last <b>NESS</b>	15. MOTHER'S MAIDEN NAME First <b>SUSIE</b> Middle <b>LYON</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>1540</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary</b> of the <b>Post-Digmoia</b> <b>Colon</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic Pulmonary Tuberculosis</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/31, 1968</b> , to <b>1/11, 1969</b> , that (I) (we) last saw the deceased alive on <b>1/11, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W Newcomer</b>		DEGREE <b>M.D.</b>	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>1/4/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		22e. ADDRESS <b>Mount Wilson, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>1-14-1969</b>	23c. NAME OF CEMETERY OR CREMATORY <b>1st Reform Church Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Pompton Plains, New Jersey</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave.</b>		25a. REC'D BY REGISTRAR DATE <b>13 1969</b>	25b. REGISTERED <b>1/4/69</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
BENJAMIN				EISENSTEIN	JANUARY 29, 1969		6:30 P.M.		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE		12-20-1898		70 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
BALTIMORE, MD.		U.S.A.				HIGH SEAS BALTIMORE MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE, MD.		GREEK SHIP OLYMPIA		MERCHANT		RETAIL			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		Baltimore		BALTIMORE				FLEETWOOD APTS. 5935 WESTERN RUN DRIVE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT Address	
MAX		EISENSTEIN		ANNA M.				MR. A. MORTON EISENSTEIN, 2427 DIANA RD. #9	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)					Acute Myocardial Infarction				
DUE TO, OR AS A CONSEQUENCE OF					Pulmonary oedema.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 29, 1969, to Jan 29, 1969, that (I) (we) last saw the deceased alive on Jan 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS		22c. DATE SIGNED			
NICOLAOS GALACOS				9. Porioti Str. - ATHENS/GREECE		Jan. 31, 69			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		2-2-69		SHAAREI TFILOH		BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR				25a. REC'D BY		25b. DATE			
SOL LEVINSON & BROS., 6010 Reisterstown Road				FEB 6 1969		FEB 6 1969			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Every delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR M	
FREDERICK MORRIS EMM						19			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	
male	white	Dec. 18, 1928	40 YRS					January 18, 1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR noon M	
Pennsylvania		U.S.A.				Baltimore			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore			8105 Kirkwall Court			Driver		Trucking	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Baltimore		Towson		8105 Kirkwall Court		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Fredrick A. Emm			Irene E. Mosier						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
Yes Korean			216-24-7398		Joseph N. Emm 10107 Tipperary Rd. 21234				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> 4307 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			Werner U. Spitz, M.D.		M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 1/19/69		
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/21/69		Mt. Maria		Baltimore Co., Maryland			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REG. STRAR DATE		25b. REGISTRAR'S SIGNATURE	
Wm E. Johnson 8521 Loch Raven Blvd 21204						JAN 22 1969		J. Charles Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-60

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print) <b>Dorothy May Emmel</b>			First Middle Last			2a. DATE OF DEATH 1 Month 4 Day 69 Year		2b. HOUR 6:52 PM		
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>9/14/08</b>		6. AGE (In years last birthday) <b>60</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>9516 Harford Rd. #34</b>	
14. FATHER'S NAME <b>Louis H. Kromm</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Josie Mae Armiger</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>family records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Camilo F. Tomboc</b>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/14/69</b>				
22d. PHYSICIAN'S NAME (Type) <b>Dr. Camilo Tomboc</b>		22e. ADDRESS <b>St. Joseph Hospital</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>1/8/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. County, Md.</b>				
24. FUNERAL DIRECTOR <b>C. F. EVANS &amp; SON</b>		ADDRESS <b>8802 Harford Road</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 6 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
10366											
CERTIFICATE OF DEATH											
00364											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		
Edward							Evans		January 3, 1969		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. AGE (In years last birthday)		
male		Negro		March 23, 1892			76		YRS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				12b. HOUR a. 15 M	
Va.		U. S.				Baltimore				Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville			SPRING GROVE STATE HOSP.			laborer					
13a. USUAL RESIDENCE (Where deceased admitted) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Md.			Balto.			Catonsville			unknown		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		
First Middle Last			First Middle Last						219-54-3538J		
						17. INFORMANT			Address		
						Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) GENERALIZED ARTERIOSCLEROSIS YEARS											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Oct. 29, 1968, to Jan. 3, 1969, that (I) (we) last saw the deceased alive on Jan. 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
Alberto M. Gutierrez						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			1-3-69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Alberto M. Gutierrez						Spring Grove State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Removal			Jan. 9, 69			St. Anthonys Brook			BALTIMORE, Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Frank A. Newell, Inc.						JAN 13 1969			James J. J.		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be expedited within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
CERTIFICATE OF DEATH																
1 DECEASED-NAME (Type or print)			First <i>Ethelyn</i>			Middle <i>Everett</i>			Last <i>Everett</i>			2a. DATE OF DEATH Month <i>1</i> Day <i>25</i> Year <i>69</i>			2b. HOUR <i>10:30 PM</i>	
3 SEX <i>Female</i>			4. RACE <i>White</i>			5 DATE OF BIRTH <i>3-28-91</i>			6 AGE (In years lost birthday) <i>77</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Summerset Gwty</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Baltimore</i>			Md				
10 CITY OR TOWN OF DEATH <i>GARRISON, Md.</i>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Foxleigh Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Balto.</i>			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <i>2840 Cubb Hill Rd.</i>				
14 FATHER'S NAME First <i>Joseph</i> Middle <i>W.</i> Last <i>Barkley</i>			15 MOTHER'S MAIDEN NAME First <i>MARY</i> Middle <i>Toavine</i> Last <i>Toavine</i>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/>			16b. SOCIAL SECURITY NO.			17 INFORMANT										
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>weeks</i> <i>years</i>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Septicemia etiology unknown</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <i>12-7-67</i> , 19 <i>67</i> , to <i>1-25-69</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1-23-69</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>David J. Miller</i>			DEGREE <i>MD.</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (Type) <i>David J. Miller</i>			22e. ADDRESS <i>9115 Rockstar Town Rd. Annapolis Mills, Md.</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>1-30-69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Mohland Memorial Park</i>			23d. LOCATION (City or Town) (County) (State) <i>Balto Md.</i>							
24. FUNERAL DIRECTOR <i>Mr. J. Tedbnew &amp; Sons</i>			ADDRESS <i>Balto, Md.</i>			25. FILED BY REGISTRAR <i>FEB 3 1969</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card on papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00366									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
LORRAINE V. FAMBACK						January 9, 1969		6:00AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		June 26, 1905		65 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				Baltimore			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		8426 Greenway Rd. Balto., Co.		Clerk		Dept. Store			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		21204				8409 Loch Raven Blvd.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MA DEN NAME			First Middle Last
Thomas			Driscoll			Belle			Weidman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address
No			214 14 5268			James A. Gede 612 Piper Road			21136
18. CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>1538</u> <u>relastatic carcinoma, abd.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma, Colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2 yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>12-6</u> , 19 <u>66</u> , to <u>1-9</u> , 19 <u>69</u> , that (I) ( <input checked="" type="checkbox"/> ) last saw the deceased alive on <u>1-8</u> , 19 <u>69</u> , and that in (my) ( <input checked="" type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <input checked="" type="checkbox"/> ) did not view the body after death.									
22b. SIGNATURE <u>Joseph F. LiPira M.D.</u>					22c. DATE SIGNED <u>1/10/69</u>		22d. PHYSICIAN'S NAME (Type) Joseph F. LiPira M.D.		
22e. ADDRESS 8400 Loch Raven Blvd. Balto., Md. 21204									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/11/69		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR William E. Johnson 8521 Loch Raven Blvd. 21204					25a. REC'D BY REGISTRAR DATE JAN 14 1969		25b. REGISTRAR'S SIGNATURE <u>William E. Johnson</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10367

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10367

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
William Arthur Fish			PAW			Jan 23/69			5 A-M					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		white		Dec 8 - 1883			85 YRS.		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Maryland			U.S.A.						Baltimore					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Uppermer						Hammer + Hueston								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Baltimore			Uppermer			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rural		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Lewis			Fishman			Ananda			Kingling					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address					
No			217-12-1170			Mrs Wm Warner			Uppermer, Md			21155		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)														
4124 DUE TO, OR AS A CONSEQUENCE OF														
Acute Heart Failure														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
(b) Arteriosclerotic Cardiovascular Disease														
DUE TO, OR AS A CONSEQUENCE OF														
Disease														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
Chronic Bronchitis														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No			City or Town			County State		
22a. I certify that (I) (this hospital) attended the deceased from Sept 1955, to Jan 23, 1969, that (I) (we) last saw the deceased alive on Jan 23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			22c. DATE SIGNED											
W H Ford M.D.			1-23-69											
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS											
W. H. Ford M.D.			Manchester, Md 21102											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			Jan. 25, 1969			Trenton Cemetery			Upperco, Md.					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Tipton - Kline Funeral Home			Hampstead, Md.			JAN 27 1969			Charles Judae					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR  
304A REV 1-68

MARTIN LUTHER KING, JR. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) First Middle Last <b>WILLIAM HENRY FORD</b>					2a. DATE OF DEATH Month Day Year <b>January 1 1969</b>		2b. HOUR <b>10P</b>		
3. SEX <b>Male</b>		4 RACE <b>Cau.</b>		5. DATE OF BIRTH <b>Sept. 5, 1885</b>		6. AGE (In years last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> D.VORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Long Green Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Stationary Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Paper Co.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Monkton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Blue Mount Road</b>	
14. FATHER'S NAME First Middle Last <b>William Henry Ford</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Georgianna Lovett</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-10-2411A</b>		17. INFORMANT Address <b>Mary F. Heaps, Same as # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Boonch - pneumonia</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>Arteriosclerosis</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 19 68</b> to <b>Jan 1 1969</b> , that (I) <del>two</del> saw the deceased alive on <b>Jan 1 1969</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> <del>did</del> (did not) view the body after death.									
22b. SIGNATURE <b>W. G. Helgeson MD</b> DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1-2-69</b>		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE <b>Jan. 4, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>White Hall, Balto. Co. Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204</b>					25a. REC'D BY REGISTRAR <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 7 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b HOUR
HERMAN W FORNOFF						JANUARY 13, 1969			2:40A M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years lost birthday)		7 UNDER 1 YEAR	
MALE		CAUCASIAN		SEPTEMBER 23, 1907		61 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Balto., Md.		U.S.A.				BALTIMORE Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
FORT HOWARD,			HOSPITAL VETERANS ADMINISTRATION			Restaurant Operator			Self
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before address not a State)				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND						BALTIMORE		3441 E LOMBARD STREET	
14 FATHER'S NAME			First	Middle	Last	5 MOTHER'S MAIDEN NAME			First Middle Last
WILLIAM					FORNEFF	ELIZABETH			SCHUTTE
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT Address			
YES			WW II			CLINICAL RECORDS, VA HOSP, FT HOWARD, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL									
472X DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMPHYSEMA									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
DIABETES MELLITUS AND OBESITY									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/24/68, 19__, to 1/13/69, 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1/13/69, 19__, and that <input checked="" type="checkbox"/> (our) opinion of death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE <i>J. D. Talbert, M.D.</i>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 1/13/69		
22b. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.					22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND				
23a BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		1-16-69.		OAK LAWN CEMETERY		BALTIMORE, MARYLAND			
24 FUNERAL DIRECTOR <i>E. Charles S. Zeiler</i>					ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
ZEILER FUNERAL HOME, 6224 EASTERN AVE, BALTO, MD					JAN 16 1969				<i>James L. Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Robert			John	FOX	Month 1 Day 2 Year 1969			1 45 PM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		August 10, 1912		56 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
200' Len		"				Baltimore, Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Towson			St. Joseph Hospital						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Baltimore		Baltimore		2441 Ellis Rd.		
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Archibald Fox						Lilia Bezo's			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT Address				
			216-03-3624		Lena R. Fox-2441 Ellis Road-21234				
18 CAUSE OF DEATH (Enter only one cause per me for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) Chronic Pulmonary Emphysema									
491X DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21c. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 12/30/1968, to 1/2/1969, that (X) (we) last saw the deceased alive on 1/2/1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death									
22b SIGNATURE			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)			7620 York Rd., Towson, Md. 21204						
Samuel Lee, M.D.									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
1-1-69				Glenview Park		Towson, Md.			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
G. S. Miller Inc - 715 Calver St. - 21202				JAN 7 1969		Charles Judge			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Ora E. Frederick						Jan. 5 1969			M
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 IF UNDER 1 YEAR	
Female		White		12/10/77		91 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Baltimore		USA				Baltimore County Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Catonsville		Summit Nursing Home		Housewife					
13a USUA. RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d HOUSE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Balto.		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		319 Greenlow Rd. (28)	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Late - Burgan									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT Address					
No		--		Mr. W. Everett Frederick, 319 Greenlow Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary of Val. Block</i>								<i>2 hours</i>	
1560 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<i>Alcohol intake. Hypertension C.V.D.</i>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED at work <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 4</i> , 1964, to <i>Jan 5</i> , 1969, that (I) (we) last saw the deceased alive on <i>Jan 4</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Dr. Nelson McKay</i>		22c DATE & GNFD <i>1/6/69</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS							
Dr. Nelson McKay									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		1/6/69		Lorraine Park Cem.		Baltimore, Maryland			
24 FUNERAL DIRECTOR		ADDRESS		25a JAN 7 1969		25b REGISTRAR'S SIGNATURE			
Witzke, 4101 Edmondson Ave., Balto.									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

00373

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00372

# CERTIFICATE OF DEATH

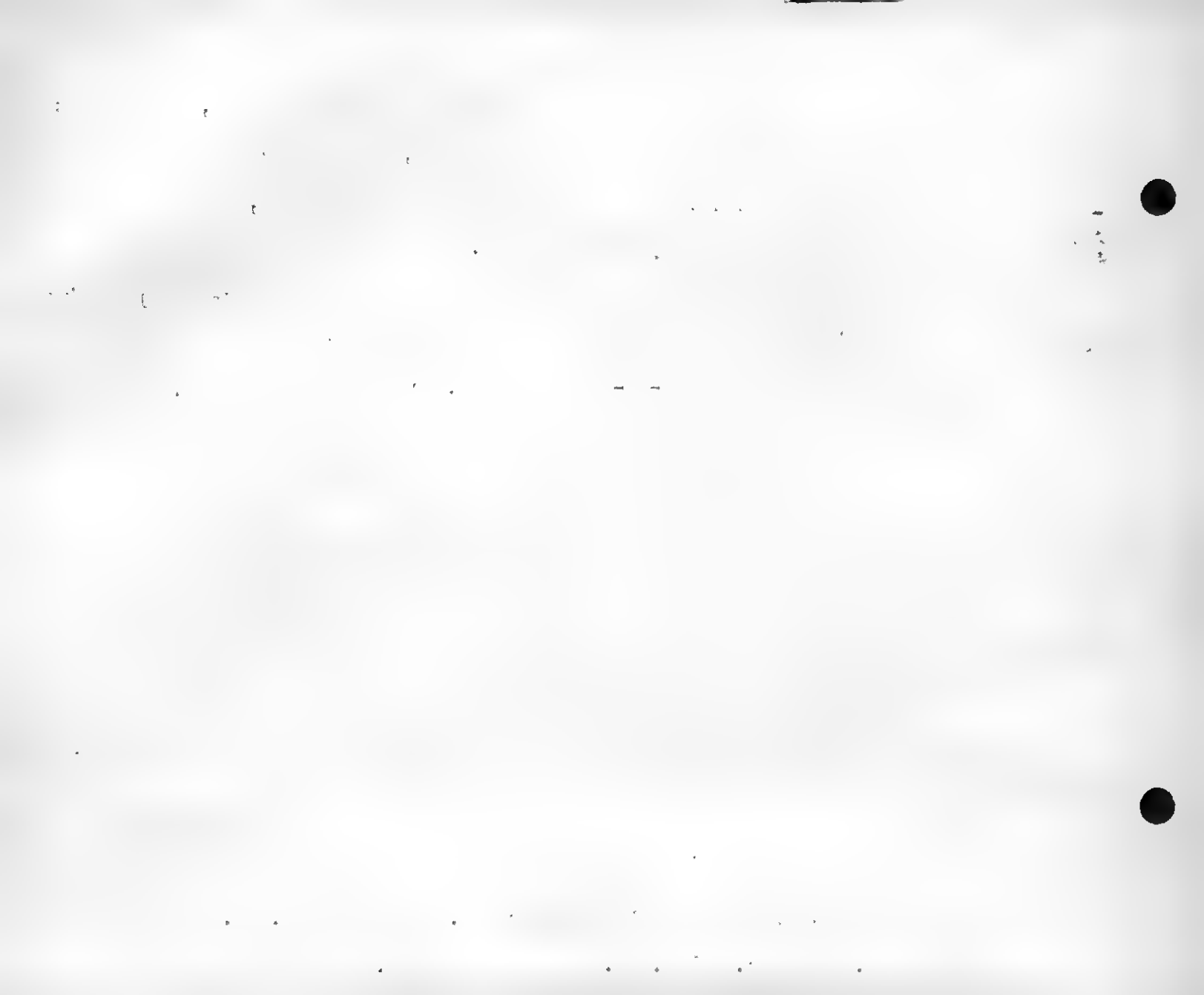
1. DECEASED NAME (Type or print) <b>BEN SHAW I FRIEDMAN</b>		First Middle Last		2a. DATE OF DEATH Month <b>1</b> Day <b>9</b> Year <b>1968</b>		2b. HOUR <b>11</b> MIN <b>10</b>	
3. SEX <b>M</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>9-17-08</b>		6. AGE (in years last birthday) <b>60</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTO County</b>	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>BALTO City GEN</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>POST OFFICE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gov't</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>1 Albee St</b>		14. FATHER'S NAME <b>Samuel</b>		15. MOTHER'S MAIDEN NAME <b>Ann</b>		15. MOTHER'S MAIDEN NAME First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no or unknown) <b>No</b>		16b. SOCIAL SECURITY NO <b>215-098049</b>		17. INFORMANT <b>Mrs Lillian Friedman</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIOVASC DIS.</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b> <b>10 YRS</b>							
19a. DATE OF OPERATION <b>0</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>0</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>0</b> <b>0</b> <b>1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nonwhile <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) <b>OFFICE BUILDING, ETC</b>		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-1</b> , 19 <b>68</b> , to <b>1-9</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>1-9</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>H. Gerard Oster MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-9-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>H. GERARD OSTER MD</b>				22e. ADDRESS <b>6821 Reisterstown Rd Balto</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/10/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Anshe Emunah City Chaim</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto Md</b>	
24. FUNERAL DIRECTOR <b>Lillian L. Lewis &amp; Son Inc. 9610 Prieststown Rd</b>				25a. REC'D BY REGISTRAR <b>JAN 13 1969</b> DATE <b>1/9/69</b> REGISTRAR <b>Barbara T. Henderson</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Elizabeth Hattie FUCHS						JANUARY Month 20, Day 1969 Year			1:15 A M
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS
Female		White		March 20, 1898		70 YRS.		MONTHS	DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore, Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INST. (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work on life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Towson		St. Joseph Hospital		Homemaker					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET AND NUMBER		13e APARTMENT OR ROOM NO.	
Maryland		Baltimore				4902 Arabia Ave 14		#2235	
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Peter					Granlund	Bridgett			Deavit
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address				
no			214-38-5269		Georg G. Fuchs 3310 Ramona Ave. 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardiac respiratory insufficiency									
199.1 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) carcinomatosis -- primary either colon or breast									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOLR A.M. Month Day Year P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)		21f LOCATION		Street or R.F.D. No.		City or Town	County State
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from January 3, 1969, to January 20, 1969, that (I) (we) last saw the deceased alive on January 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED			
Ines Cilliani						1/20/69			
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS							
Ines Cilliani, M.D.		7620 York Rd., Towson, Md. 21204							
23a BURIAL, CREMATION, or other disposition (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
Burial		1/23/69		Holy Redeemer Cem.		Balto. Md.			
24. FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Leonard J. Ruck Inc. Balto. Md.				JAN 22 1969		[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print) First <b>LENA</b> Middle <b>ELIZABETH</b> Last <b>FUSZ</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>25</b> Year <b>69</b>			2b. HOUR <b>5:15 PM</b>			
3 SEX <b>FEMALE</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH <b>4-28-1897</b>		6. AGE (in years last birthday) <b>71</b> YRS.		7. UNDER YEAR MONTHS DAYS <b>69</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>BMC, TOWSON, MD. 21204</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RET.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>611 Anneslie Rd.</b>			
14. FATHER'S NAME First <b>Deck</b> Middle <b>Deck</b> Last <b>Deck</b>			15. MOTHER'S MAIDEN NAME First <b>Katherine</b> Middle <b>Katherine</b> Last <b>Katherine</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>219-16-3420A</b>		17. INFORMANT Address <b>Mr. William J. Fusz 611 Anneslie Rd</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute exacerbation Chronic</b> <b>2041</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>lymphatic leukemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Left lower lobe pneumonia w/probable septicemia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1-23-</b> , <b>1969</b> , to <b>1-25-</b> , <b>1969</b> , that (I) (we) last saw the deceased alive on <b>1-25-</b> , <b>1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>DR. GEORGE PIKLER</b>				22c. DATE SIGNED <b>1-25-69</b>		22d. PHYSICIAN'S NAME (Type) <b>DR. GEORGE PIKLER</b>			
22e. ADDRESS <b>6701 N. Charles Street</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/28/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>mitchell - whelshel</b>		ADDRESS <b>4509 Home York Rd.</b>		25a. REC'D BY REGISTRAR <b>JAN 27 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

00373

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00375

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Eva</b>			First Middle Last <b>Gallick</b>			2a DATE OF DEATH Month Day Year <b>January 5, 1969</b>			2b. HOUR a m <b>7:30 a</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>December 24, 1902</b>			6 AGE (In years last birthday) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b CIT ZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Baltimore</b> Md.						
10. CITY OR TOWN OF DEATH <b>Dundalk</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <b>3458 Sollers Pt. Rd.</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>**</b>				
13a USUAL RESIDENCE (Where deceased lived admission) STATE <b>Penna.</b>			13b COUNTY <b>Luzerne</b>			13c CITY OR TOWN <b>Nanticoke</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <b>238 West Noble Street</b>	
14 FATHER'S NAME <b>Jacob</b>			First Middle Last <b>Gallick</b>			15 MOTHER'S MAIDEN NAME <b>Mary</b>			First Middle Last <b>?</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>119-10-8809</b>			17 INFORMANT <b>John Makovic</b>			Address <b>2013 Denbury Dr. Balt. Md. 21222</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Disease</b> <b>4122</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HCVI</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, not by medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State							
22a I certify that (I) (this hospital) attended the deceased from <b>1/27</b> , 19 <b>69</b> , to <b>1/5</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1/5</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Theodore C. Patterson M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>1/5/69</b>				
22d. PHYSICIAN'S NAME (Type) <b>Dr. Theodore C. Patterson M.D.</b>						22e ADDRESS <b>3427 Dundalk Ave. Balt. 21222 Md.</b>							
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE <b>Jan 8, 1969</b>			23c NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>			23d LOCATION (City or Town) (County) (State) <b>Nanticoke Luzerne Penn a.</b>				
24. FUNERAL DIRECTOR <b>John J. Duda</b>						ADDRESS <b>1922 Wise Ave. Balt. 21222 Md.</b>			25a. REC'D BY REGISTRAR <b>JAN 8 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles J. George</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00380

CERTIFICATE OF DEATH

00376

1. DECEASED-NAME (Type or print) <b>Johanna Friedericke Garde</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>13</b> Year <b>69</b>			2b. HOUR <b>11:35</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>October 16, 1880</b>		6. AGE (In years lost birthday) <b>88</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <b>Augsburg Home 6811 Campfield Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before address on) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>625 Braeside Road</b>							
14. FATHER'S NAME First <b>Christoph F.</b> Middle <b>Dederer</b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>Katharina</b> Middle <b>Köhler</b> Last <b></b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>218-52-0545-11</b>		17. INFORMANT <b>T.W. Katenkamp</b>		Address <b>9128 Bengal Rd Randallstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart Disease</b> <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Influenza</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Senile Psychosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND CLASH <b>- 5 yrs</b> <b>3 wks</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Generalized Arterio Sclerosis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>68</b> , to <b>July-19</b> , 19 <b>69</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>July 10</b> , 19 <b>69</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.							
22b. SIGNATURE <b>Earl L. Chambers - M.D.</b>				DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/14/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers - M.D.</b>				22e. ADDRESS <b>110 - W. Cold Spring Path - Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1/15/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR <b>W. A. Deemann</b>		ADDRESS <b>6067 Fay Rd</b>		25a. REC'D BY REGISTRAR <b>JAN 16 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# FOR STATE HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 19. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-1, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
DECEASED NAME (Type or Print) <i>Edward Raymond Gardiner</i>			First Middle Last			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <i>Jan 20 1969</i>		2b HOUR OF DEATH <i>5:15 P.M.</i>	
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH <i>Jan 15 1893</i>	6 AGE (In years last birthday) <i>79 YRS</i>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year <i>Jan 20 1969</i>		2d HOUR <i>7:15 P.M.</i>	
7a BIRTHPLACE (State or foreign country) <i>Ind</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Balto</i>			
10 CITY OR TOWN OF DEATH <i>Balto</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8931 Salyer Hill</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
3a USUAL RESIDENCE (Where deceased lived, if not in hospital, give street address) STATE <i>Ind</i>		13b COUNTY <i>Balto</i>		13c CITY OR TOWN <i>Balto</i>		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <i>8931 Salyer Hill</i>	
14 FATHER'S NAME <i>John W. Gardiner</i>				15 MOTHER'S MAIDEN NAME <i>Alice Barber</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>			16b SOCIA. SECURITY NO. <i>26-5-4953</i>		17 INFORMANT <i>Nellie Gardiner</i> ADDRESS <i>8931 Salyer Hill</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic Cardiovascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Sudden</i> (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Known thoracic aortic aneurysm</i>									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>F.T. KASIK JR</i>				EXAMINER'S NAME (Type) <i>F.T. KASIK JR</i>		CHIEF MED. CAL EXAMINER <input type="checkbox"/> ASS STANT MED. CAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <i>1/20/69</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>1/23/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Calvary Chapel Cemetery</i>			23d LOCATION (City or Town) (County) (State) <i>Beartown, Penna.</i>		
24. FUNERAL DIRECTOR <i>Wm. E. Johnson</i> ADDRESS <i>8521 Loch Raven Blvd. 21204</i>				25a REC'D BY REGISTRAR <i>IAN 22 1969</i>		25b REGISTRAR'S SIGNATURE <i>Charles Young</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00382

00378

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b> c. LENGTH OF STAY IN IS <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5 Garrett Avenue</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b> d. STREET ADDRESS <b>5 Garrett Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Daniel Warfield Garrett</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>Jan. 16, 19 69</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Negro</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Oct. 3, 1893</b>	
<b>9. AGE</b> (In years last birthday) <b>75 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Post Office</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Arbutus Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>William Garrett</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sophia Richardson</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War I</b>		<b>16. SOCIAL SECURITY NO.</b> <b>215-46-6161</b>		<b>17. INFORMANT</b> Address <b>Basil Garrett- 5 Garrett Avenue</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4109</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>MYOCARDIAL INFARCTION</b> (a), stating the underlying cause last. DUE TO <b>GENERALIZED ARTERIOSCLEROSIS</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>5-10-1966</b> <b>to</b> <b>mar 1968</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>mar 1968</b> , <b>and that death occurred at</b> <b>4:15 PM</b> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>George E. Grolegu M.D.</b>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>1-20-69</b>	
<b>22c. PHYSICIAN'S NAME</b> <b>George E. Grolegu M.D.</b>				<b>22d. ADDRESS</b> <b>5806 Main Street- Elkridge 27, MD.</b>			
<b>23b. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23c. DATE THEREOF</b> <b>1/21/69</b>		<b>23d. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore National Cem.</b>		<b>23e. LOCATION</b> (City, town or county) (State) <b>Baltimore, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Herbert E. Nutter-3035 W. North Ave.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE JAN 21 1969</b>			
				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles J. Jager</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	2b. HOUR	
ROSE			C.		GECKLE		JANUARY		Month 13, Day 1969	11:25 P	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		
FEMALE		WHITE		FEBRUARY 18, 1887			81 YRS		IF UNDER 24 HRS		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		10			
MARYLAND		U.S.A.		BALTIMORE		BALTIMORE		Md			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
TOWSON			ST. JOSEPH HOSPITAL			HOMEMAKER					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b CITY OR TOWN		13c INSIDE CITY, IN 157		13d STREET AND NUMBER		13e		
MARYLAND			BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>		300 LINCOLN AVE. #21093				
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
Francis			X		Katzenberger		Mary		Speigel		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b SOC. SEC. NO.		17 INFORMANT		Address				
No			217-26-3756		Jerome W Geckle		206 Abbey Hill Ct.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive gastro-intestinal hemorrhage											
DUE TO, OR AS A CONSEQUENCE OF (b) acute superficial ulceration of stomach											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Lymphoma.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. Month Day Year								
21d INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from January 13 19 69, to January 13 19 69, that (I) (we) last saw the deceased alive on January 13, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (aid not) view the body after death											
22b SIGNATURE						22c DATE SIGNED					
Christina Feliciano, M.D.						1/14/68					
22d. PHYSICIAN'S NAME (Type)						22e ADDRESS					
Christina Feliciano, M.D.						7620 York Rd., Towson, Md. 21204					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			1/16/69			New Cathedral			Baltimore Maryland		
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
Leonard J Ruck INC. Baltimore, Maryland						JAN 15 1969			Charles Judge		



## CERTIFICATE OF DEATH

00380

00380

1. DECEASED NAME (Type or print) First Middle Last VIOLET M. GEPPI			2a. DATE OF DEATH Month Day Year JAN 23 1969		2b. HOUR M
3. SEX F	4. RACE W	5. DATE OF BIRTH SEPT. 12, 1907	6. AGE (In years last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH BALTIMORE Md		
10. CITY OR TOWN OF DEATH CATONSVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DUNMORE RD	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SECRETARY	12b. KIND OF BUSINESS OR INDUSTRY BANK		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD	13b. COUNTY BALTIMORE	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? NO	13e. STREET AND NUMBER DUNMORE RD.	
14. FATHER'S NAME First Middle Last ELMER TOLSON			15. MOTHER'S MAIDEN NAME First Middle Last MARY LYON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 217-128667	17. INFORMANT Address Mrs. Joyce Wilson - 6 Dunmore Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Insufficiency DUE TO, OR AS A CONSEQUENCE OF Sarcoidosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from Jan 19 63 to Jan 23 19 69, that (I) (we) last saw the deceased alive on Jan 20 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James Nolan		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 1/23/69	
22d. PHYSICIAN'S NAME (Type) J. S. NOLAN		22e. ADDRESS Balt Md 21229			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-27-69	23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.		23d. LOCATION (City or Town) Balto.	(County) (State) Ind.
24. FUNERAL DIRECTOR Joyce - Conway P.H.		ADDRESS Catonville		25a. REC'D BY REGISTRAR DATE JAN 29 1969	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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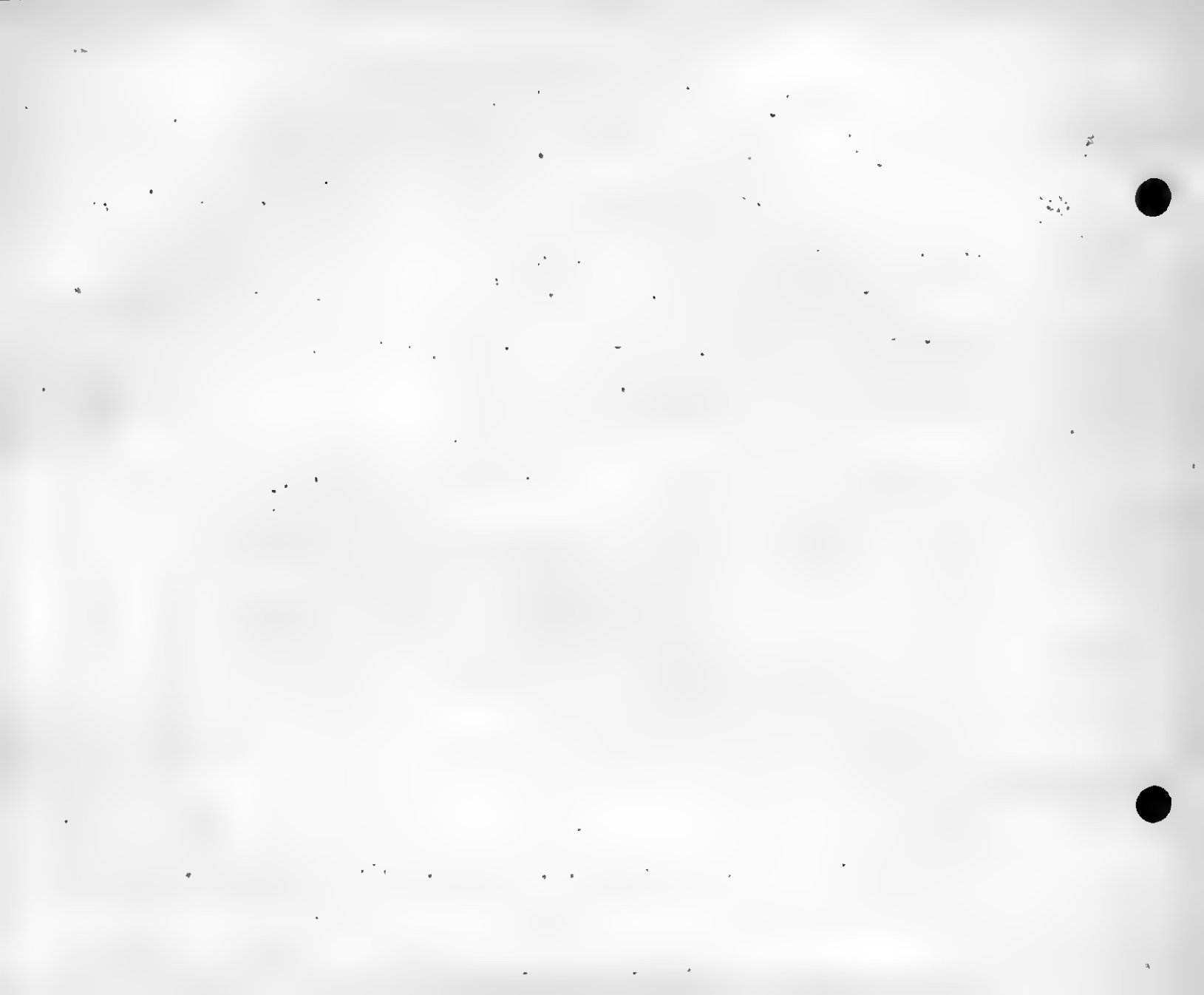
VR A15 (4-68)  
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Emma Grace Gilbert</i>			2a. DATE OF DEATH Month <i>1</i> Day <i>28</i> Year <i>69</i>			2b. HOUR <i>8 P M</i>			
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>6-3-1879</i>		6. AGE (In years last birthday) <i>89</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>America</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore County Md.</i>			
10. CITY OR TOWN OF DEATH <i>Lutherville, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>College Manor 500 Seminary Ave.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4507 Liberty Hts. Ave.</i>	
14. FATHER'S NAME First Middle Last <i>James Gilbert</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Emma Kaufman</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-4836251</i>		17. INFORMANT <i>Howard L Gilbert, Jr.</i>			Address <i>21022</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1. pneumonia</i> <i>4/12/69</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>ASCLD - marked by society</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Days</i> <i>Years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>67</i> , to <i>Jan</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Jan 21 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>RK Gundry</i>				DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1-22-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Richard K. Gundry, M.D.</i>				22e. ADDRESS <i>2 W. University Pkwy. Balto, Md. 18</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-30-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>		23d. LOCATION (City or Town) (County) (State) <i>Woodlawn Md</i>			
24. FUNERAL DIRECTOR <i>Wm. Cord Burke</i>		ADDRESS <i>Burke Town</i>		25a. REC'D BY REGISTRAR <i>100 York Rd</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>FEB 3 1969</i>	

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. FRESTEN STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or Print)		First HARRY		Middle Randall		Last GILL		2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year		2b HOUR
3 SEX Male		4 RACE White		5 DATE OF BIRTH Feb. 8, 1941		6 AGE (in years at birthday) 27 YRS.		7c DATE PRONOUNCED DEAD Month Day Year		7d HOUR
7a BIRTHPLACE (State or foreign country) Glyndon		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore				
10 CITY OR TOWN OF DEATH Maryland Farms		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Glenan Rd. E. of Longgreen Pike		12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if admission) STATE Maryland		13b COUNTY Balto.		13c CITY OR TOWN Maryland Farms		13d INSIDE CITY LIM 15? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER		
14 FATHER'S NAME Joshua		First L.		Middle Gill Sr.		Last		15 MOTHER'S MAIDEN NAME Helen		Middle Talbert Gill
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service)		16b SOCIAL SECURITY NO 216-38-4674		17 INFORMANT Mr. Joshua L. Gill Sr.		ADDRESS Glyndon, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Neck										
8170 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year 3:19 PM 1-3- 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver in one car accident				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f LOCATION Street or R.F.D. No Glenan Rd. E. of Longgreen Pike		City or Town Balto. M.D.		County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Ronald N. Kornblum, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 1/3/69		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE Jan. 6, 1969		23c NAME OF CEMETERY OR CREMATORY Grace Methodist Cemetery		23d. LOCATION (City or Town) (County) (State) Falls Rd. & Ridge Rd. Balto. Co.				
24 FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.				ADDRESS		25a REG. BY REG. STRAR DATE JAN 6 1969		25b REGISTRAR'S SIGNATURE Charles Judge		



00387

## CERTIFICATE OF DEATH

00383

1. DECEASED-NAME (Type or print) <b>ANTHONY</b>			First <b>P.</b>			Middle <b>Gilles</b>			Last <b>Gilles</b>			2a. DATE OF DEATH <b>Jan</b> Month <b>17</b> Day <b>69</b> Year			2b. HOUR <b>530 P</b> M					
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>10-26-1919</b>			6. AGE (In years last birthday) <b>49</b> YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS HOURS MIN					
7a. BIRTHPLACE (State or foreign country) <b>Iowa</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Balto.</b> Md.											
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7 Hillside Ave.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Office Manager</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Contactor</b>											
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>			13c. CITY OR TOWN <b>Towson</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>7 Hillside Ave.</b>								
14. FATHER'S NAME <b>Herman</b>			First <b>Gilles</b>			Middle <b>Anna</b>			Last <b>?</b>			15. MOTHER'S MAIDEN NAME <b>Anna</b>			First <b>?</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) <b>315-09-0896</b>			17. INFORMANT <b>Helen B. Gilles</b>			Address <b>Same as # 13</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <b>October 1968</b> , to <b>Jan 17, 1969</b> , that (I) (we) last saw the deceased alive on <b>January 17, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <b>Percy H. Sutley MD</b>			DEGREE <b>MD</b>			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>Jan 17-1969</b>											
22d. PHYSICIAN'S NAME (Type) <b>Percy H. Sutley</b>			22e. ADDRESS <b>300 5 St. Paul St. Balto., Md. 21218</b>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>1-21-1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney &amp; Valley Mem. Gar.</b>			23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Md.</b>											
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks</b>			ADDRESS <b>Towson 1050 York Rd. 21204</b>			25a. REC'D BY REGISTRAR <b>JAN 21 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First <b>Frieda</b>		Middle <b>M.</b>		Last <b>Gilpin</b>		2a. DATE OF DEATH Month <b>1</b> Day <b>7</b> Year <b>1969</b>		2b. HOUR <b>2:20 PM</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>August 10, 1878</b>			6. AGE (In years last birthday) <b>90</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>					
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Presbyterian Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Towson</b>		13d. INS. OF CITY, COUNTIES YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Dixie Dr. 1902</b>	
14. FATHER'S NAME First <b>Frederick</b> Middle <b>G.</b> Last <b>Genso</b>			15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>Aeby</b> Last <b>Aeby</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Presbyterian Home Dixie Dr. Towson Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 YRS.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home farm, street, factory, office, building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 1, 1964</b> to <b>JAN 2, 1969</b> , that (I) (we) last saw the deceased alive on <b>12-31-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>S. J. VENABLE, JR. M.D.</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1-9-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>S. J. VENABLE, JR. M.D.</b>						22e. ADDRESS <b>7215 YORK RD - BALTIMORE MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1/9/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Balto. Md.</b>				
24. FUNERAL DIRECTOR <b>Mitchell Wiedefeld Home 6500 York Rd.</b>						25a. REC'D BY REGISTRAR <b>JAN 14 1969</b>		25b. SIGNATURE OF REGISTRAR			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

00385

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00385

1 DECEASED-NAME (Type or print) <b>JAMES</b>		First Middle Last		2a. DATE OF DEATH Month Day Year <b>January 24, 1969</b>		2b. HOUR <b>4:15 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 9, 1911</b>		6. AGE (In years last birthday) <b>57</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Chevrolet GM Assembly</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY L.M. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>3806 Woodlea Ave.</b>		13f. CITY OR TOWN <b>Baltimore</b>		13g. STATE <b>Md</b>		13h. ZIP CODE <b>21206</b>	
14. FATHER'S NAME <b>Ranson</b>		First Middle Last <b>C Gist</b>		15. MOTHER'S MAIDEN NAME <b>Virginia</b>		First Middle Last <b>G Lockard</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO <b>217-01-5110</b>		17. INFORMANT <b>Catherine A Gist</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung Carcinoma</b> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 1B)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>November 30, 1968</b> to <b>January 24, 1969</b> , that (I) (we) last saw the deceased alive on <b>January 24, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Antonio de Leon M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1-24-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Antonio de Leon, M.D.</b>				22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/27/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc, Baltimore, Maryland</b>				25a. REC'D BY REGISTRAR <b>JAN 27 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
00386									
1. DECEASED NAME (Type or print) First Middle Last <i>Elizabeth C. Cornbus</i>			2a. DATE OF DEATH Month Day Year <i>1 18 69</i>			2b. HOUR <i>10A</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Jan. 6, 1891</i>		6. AGE (In years last birthday) <i>78</i> YRS		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Balt. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Stella Maris Hospice</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Sales lady</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Medley Villa Wood Road</i>	
14. FATHER'S NAME First Middle Last <i>George Schneider</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Ratarina Wilhelmina Rehtine</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO <i>214-22-1638</i>		17. INFORMANT Address <i>Katherine Kischer, P.H. Stella Maris Hospice</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs -</i> <i>7rs -</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>July 24, 1968</i> , to <i>Jan. 18, 1969</i> , that (I) (we) last saw the deceased alive on <i>November 30, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>E Lee Robbins</i> M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1/18/69</i>					
22d. PHYSICIAN'S NAME (Type) <i>Dr. E Lee Robbins</i>		22e. ADDRESS <i>812 Mockingbird Lane Apt. 101</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1/21/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Wm E. Johnson 8521 Loch Raven Blvd 21204</i>				25a. REC'D BY REGISTRAR DATE <i>JAN 22 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 28 Film 409 1-30-69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1039

00287

1 DECEASED-NAME (Type or print) Milton Daniel Gregory			2a DATE OF DEATH 01 Month 16 Day 69 Year			2b HOUR M			
3. SEX Male		4 RACE White		5. DATE OF BIRTH 05-01-23		6. AGE (In years last birthday) 45 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto Co Gen Hosp		12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Sec Sec.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1923 Englewood Avenue #7	
14 FATHER'S NAME First Middle Last Isadore Gregory			15 MOTHER'S MAIDEN NAME First Middle Last Helen Szwabowski						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown WWII Navy		16b. SOCIAL SECURITY NO 218-16-0865		17 INFORMANT Address Anna Gregory-1923 Englewood Avenue					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Possible meningitis - took 100 mg Penicillin / 100 mg Aspirin</u> <u>5007</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Leptomeningitis assoc. with</u> DUE TO, OR AS A CONSEQUENCE OF <u>Guillain-Barre Syndrome</u> (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 DAYS	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Sumner Caldwell, MD</u>				22c. DATE SIGNED 1-16-69		22d. PHYSICIAN'S NAME (Type) DEGREE ATTENDING PHYS <input type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1-20-69		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR MARION ARMACOST-4600 Liberty Hghts. Avenue				25a. REC'D BY REGISTRAR JAN 17 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P. M.	
Augusta				Gutberlet	January 17, 1969		1:30 P.	
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
female	white		Feb. 24, 1883		85 YRS			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Czechoslovakia	U. S.				Baltimore Md.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville		SPRING GROVE STATE HOSP.		housewife (seamstress)		American Raincoat Co.		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY	13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER		
Md.		Balto.	Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	3336 Wallford Drive		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle Last
Frank				Hrabes	H. K. K. K.			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address		
No						Records: SPRING GROVE STATE HOSPITAL		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Upper airway obstruction, acute,								acute
4124 DUE TO, OR AS A CONSEQUENCE OF (b) retropharyngeal abscess, sudden,								1/2hr.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (c) from extension of left cervical adenitis								3 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
Arteriosclerotic, Cardiovascular disease, with cardiac arrest.								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (a) (this hospital) attended the deceased from July 20, 1964, to Jan. 17, 1969, that (a) (we) last saw the deceased alive on Jan. 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death								
22b SIGNATURE				22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)		
[Signature]				1-17-69		Anthony J. Young, M.D.		
22e ADDRESS				22f REC'D BY REG STRAR				
SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				JAN 21 1969				
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		1/21/69		Holy Cross Cemetery		Anne Arundel, Md.		
24 FUNERAL DIRECTOR				25a REC'D BY REG STRAR		25b REG. STRAR'S SIGNATURE		
Stevens Funeral Home, Inc. 1501 Fort Ave.				DATE JAN 21 1969		[Signature]		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print) <b>Dolores</b>		First <b>L.</b>	Middle <b>L.</b>	Last <b>Haas</b>	2a. DATE OF DEATH Month <b>January</b> Day <b>30</b> Year <b>1969</b>		2b. HOUR <b>M</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>April 29, 1933</b>		6 AGE (in years last birthday) <b>35</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS HOURS <b></b> MIN <b></b>	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>			
10. CITY OR TOWN OF DEATH <b>Dundalk</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1813 Belle Avenue</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Clerical-Thompson Wire &amp; Rope Co.</b>		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>	13b COUNTY <b>Baltimore</b>	13c CITY OR TOWN <b>Dundalk</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <b>1813 Belle Ave.</b>			
14. FATHER'S NAME First <b>Lester</b> Middle <b></b> Last <b>Wetzel</b>		15. MOTHER'S MAIDEN NAME First <b>Evelyn</b> Middle <b></b> Last <b></b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b SOCIAL SECURITY NO <b>213-30-4603</b>		17 INFORMANT (Father) <b>Mr. Lester F. Wetzel Sr.</b> Address <b>Edgemere, Md. 429 Willow Ave.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction and stenosis</b> <b>140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Rheumatic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b></b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>68</b> , to <b>Jan. 30</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Jan. 29</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Raymundo S. Magno MD</b> DEGREE <b>MD</b> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c DATE SIGNED <b>1/31/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>RAYMUNDO S. MAGNO</b>				22e ADDRESS <b>1012 Old North Point Road, Balto. Md.</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/3/69</b>		23c NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>				25a REC'D BY REGISTRAR DATE <b>FEB 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10394

10390

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)		First Charles,		Middle I.	Last Haddaway Sr.		2a DATE KNOWN OF DEATH ESTIMATED Month 1/13 Year 1969		2b H.O.B. 1/13/69	
3 SEX Male	4 RACE White	5 DATE OF BIRTH 1/1/06		6 AGE (In years last birthday) 62 YRS	7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 1 Day 13 Year 1969		2d H.O.D. 1/13/69	
7a BIRTHPLACE (State or foreign country) Brooklyn Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore				
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore Co. Gen. Hospt.				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Service Station			12b KIND OF BUSINESS OR INDUSTRY Owner	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Balto.		13c CITY OR TOWN		3d INSIDE CITY, M.D.? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 618 Military Avenue		
14 FATHER'S NAME Jessie Haddaway		First Middle Last		5 MOTHER'S M.A.DEN NAME Lillie Willey		First Middle Last				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO 212-07-9098		17. INFORMANT Charles H. Haddaway Jr. 618 Military Ave.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		J. Nelson McKay, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED Jan 13, 1969		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE Jan. 16, 69		23c NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION (City or Town) (County) (State) Windsor Mill Rd. Balto Co. Md.				
24 FUNERAL DIRECTOR Loring Byers 8728 Liberty Rd. Randallstown Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 16 1969		25b REGISTRAR'S SIGNATURE Charles J. J...		



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Josephine S. Hadsell</b>		2a. DATE OF DEATH Month <b>Jan.</b> Day <b>24</b> Year <b>1969</b>		2b HOUR <b>M</b>
3 SEX <b>Female</b>	4 RACE <b>white</b>	5. DATE OF BIRTH <b>July 30, 1882</b>		6. AGE (In years lost birthday) <b>86</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore</b> Md.	
10 CITY OR TOWN OF DEATH <b>Cockeysville</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Md. Masonic Home</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE where deceased lived, if institution Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>6001 Edmondson Ave</b>
14 FATHER'S NAME First <b>Joseph</b> Middle <b>E</b> Last <b>Dall</b>	15 MOTHER'S MAIDEN NAME First <b>Louisa</b> Middle <b>Lepper</b> Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>No</b> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO <b>220-54-6784</b>	17 INFORMANT <b>Record of Md. Masonic, Cockeysville Md.</b>		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia</b> <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio-sclerotic Vas. Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (i) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (i) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Carl F. Benson MD</b>	DEGREE <b>MD</b>	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>Jan. 24, 1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>Carl F. Benson MD</b>	22e. ADDRESS <b>5711 York Rd. - Baltimore Md 21212</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>1-27-69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn</b>	23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Md</b>	
24 FUNERAL DIRECTOR <b>W. Cork-Brook-West</b>	ADDRESS <b>6212 BALTIMORE NAT. PK. BALTIMORE, MD</b>	25a. REC'D BY REGISTRAR <b>JAN 31 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month		2b. HOUR		
DONALD FRANCIS HALL						January 29 1969		11:30 A.M.		
3 SEX	4 RACE		5. DATE OF BIRTH			6 AGE (In years in + h + m day)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male	Negro		October 20, 1927			41 YRS				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md			
Maryland	U.S.A.				Baltimore					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Fort Howard			Veterans Adm. Hospital			Porter				
13a USUAL RESIDENCE (Where deceased lived if not institution. Residence before adm ssion) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Baltimore				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		114 E. Chesapeake Avenue	
14. FATHER'S NAME			15 MOTHER'S M.A.D.N. NAME							
First Middle Last			First Middle Last							
James Martin Hall			Gertrude May Tucker							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT Address					
Yes			WW-11		213 20 16 35 Clinical Rcds VA Hospital, Fort Howard, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction, recent cardiac arrest</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral anoxia due to (a).</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septicemia</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month - Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (a) (this hospital) attended the deceased from Jan. 16, 19 69, to Jan. 29, 19 69, that (b) (we) last saw the deceased alive on Jan. 29, 19 69, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (d'd) (did not) view the body after death										
22b SIGNATURE <u>V. Chitraplee</u>					22c. DATE SIGNED		January 29, 1969			
22d PHYSICIAN'S NAME (Type)					22e ADDRESS					
VADHANA CHITRAPLEE, M.D.					VA Hospital, Fort Howard, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
BURIAL		2-3-69		BALTIMORE NATIONAL		BALTIMORE, MD				
24 FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
MORTON & DYETTE FUNERAL HOME, 1701 W LAURENS, BALTO., MD					JAN 31 1969		<u>Charles Judge</u>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH				Month	Day	Year	2b HOUR
Helen Leah Hall					1-3-1969				19			M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
Female	White	7-4-1905		63 YRS	MONTHS DAYS		HOURS MIN.		1-3-1969		M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9. COUNTY OF DEATH				
Maryland		U.S.A.		WIDOWED		DIVORCED		Baltimore County		Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUA. OCCUPATION (Kind of work done during most of work life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY						
Catonsville		Blackwell Care Center		Saleslady		May Co.						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
STATE Md.		—		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2102 E. Baltimore Street				
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME										
First Middle Last		First Middle Last										
Thomas E. Costello		Nannie A. Geaslen										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS						
No				Thomas E. Costello		7217 Old Harford Rd. 21234						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											2 years	
41 + DUE TO, OR AS A CONSEQUENCE OF Congestive heart failure												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											?	
(b) Arteriosclerotic cardio-vascular disease												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				
								YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)								
		HOURLY A.M. P.M. 19										
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASS STANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b DATE SIGNED				
EXAMINER'S NAME (Type)		J. Nelson McKay		ADDRESS (Street, city, town, or county)				Jan 7, 1969				
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State)						
Burial		1-6-1969		Moreland Memorial Park		Baltimore, Maryland						
24 FUNERAL DIRECTOR				25a REC'D BY REG STRAR				25b REG. STRAR'S SIGNATURE				
Wm. Cook-Brooks Towson 1050 York Rd. 21204				DATE 9 1969								



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Jerome Henry Hammelman</b>			2a. DATE OF DEATH <b>1</b> Month <b>29</b> Day <b>69</b> Year		2b. HOUR M
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5 DATE OF BIRTH <b>June 3, 1908</b>		6 AGE (In years lost by day) <b>60</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Baltimore,</b> Md.		
10 CITY OR TOWN OF DEATH <b>Curtis Bay</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Curtis Bay Infirmary USCG Coast Guard</b>	12a USUAL OCCUPATION (Kind of work done during most of work life even if retired.) <b>Clerk</b>		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>	13b COUNTY	13c CITY OR TOWN <b>Baltimore</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>1503 E. 33rd Street</b>	
14 FATHER'S NAME First Middle Last <b>Charles Hammelman</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Behr</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>Yes</b> (If yes give year or dates of service) <b>WW II</b>		16b SOCIAL SECURITY NO. <b>213-03-4034</b>	17 INFORMANT <b>Mrs. Anna M. Albright</b>		Address <b>Same</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (probable) minute</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Known Coronary Artery disease 2 yrs.</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 19 <b>66</b> to <b>Nov</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Nov 6</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>W P Benson, Jr.</b> DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>January 30, 1969</b>
22d. PHYSICIAN'S NAME (Type) <b>William P. Benson M.D.</b>				22e. ADDRESS <b>3502 N. Calvert Street</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE <b>2/1/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>	
24 FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>			25a REC'D BY REGISTRAR <b>JAN 31 1969</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

00390

00295

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural White Hall</b>		c. LENGTH OF STAY IN 1b <b>Yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <b>MARY EDITH IRENE HAMMOND</b>		4 DATE OF DEATH Month <b>Jan.</b> Day <b>7,</b> Year <b>1969</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Black</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1878</b>
9 AGE (In years last birthday) yrs <b>90</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>James Cordery</b>		14. MOTHER'S MAIDEN NAME <b>Frances Young</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>220-54-9308</b>	
17 INFORMANT <b>Mrs. Eva. Mitchell, Stewartstown, Pa.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary artery occlusion.</b> DUE TO <b>Generalized arteriosclerosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis.</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bleeding Peptic ulcer chronic.</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>Jan 2, 1969</b> to <b>Jan 7, 1969</b> that (I) (we) last saw the deceased alive on <b>Jan 2, 1969</b> , and that death occurred at <b>9:25 PM</b> from causes and on the date stated above.			
22a SIGNATURE <b>William O Fulton</b> M.D.		22b. DATE SIGNED <b>Jan 10 1969</b>	
22c. PHYSICIAN'S NAME (Type) <b>William O Fulton</b>		22d. ADDRESS <b>Stewartstown, Penna. 17363</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/11/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove U.M.Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Shane, Baltimore Co., Md.</b>
24 FUNERAL DIRECTOR <b>Kenneth W. Cushman</b>		25a. REC'D BY REGISTRAR <b>Jan 10 1969</b>	
ADDRESS <b>Stewartstown, Penna.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles George</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers (Pages 1) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
00400										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
Jr HN			J HANLON			January Month 4 Day 1969		2:46 <sup>a</sup> M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		
Male		White		10-9-1900		68 YRS		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				
Ireland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph's Hospital			Driver (retired)		Balto Trans		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b CITY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland			Baltimore				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9721 Harford Road	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
John J. Hanlon			Kathlyn Gordon							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address					
no			213 10 2977		family records					
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure										
DUE TO, OR AS A CONSEQUENCE OF chronic lung disease										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State						
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from December 26 1968, to January 4 1969, that (I) (we) last saw the deceased alive on January 4 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b SIGNATURE					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED	
Ines Cilliani, I. D.									January 4, 1969	
22d PHYSICIAN'S NAME (Type)					22e ADDRESS					
					7620 York Road, Towson 4, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
burial		1/7/69		Glen Haven Memorial		Anne Arundel County, Md.				
24 FUNERAL DIRECTOR					ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
C. F. EVANS & SON 8802 Harford Road							JAN 6 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the coroner pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First PATRA			Middle D.		Last HANSARD	
2a. DATE OF DEATH			January			Month 24,		Day 1969 Year	
3 SEX			Female			4. RACE			Cau.
5. DATE OF BIRTH			June 27,			1900			6 AGE (In years last birthday)
									68 YRS.
7a. BIRTHPLACE (State or foreign country)			Puerto Rico			7b. CITIZEN OF WHAT COUNTRY?			U.S.A.
8. MARRIED			<input type="checkbox"/> NEVER MARRIED			9. COUNTY OF DEATH			Baltimore
			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						
10. CITY OR TOWN OF DEATH			Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			207 Garden Road
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			Nurse			12b. KIND OF BUSINESS OR INDUSTRY			---
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			Maryland			13b. COUNTY			Baltimore
13c. CITY OR TOWN			Towson			13d. INSIDE CITY LIMITS?			YES <input type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER			207 Garden Road						
14. FATHER'S NAME			First Theodore			Middle Diaz			Last Petra
15. MOTHER'S MAIDEN NAME			First Petra			Middle Hernandez			Last Hernandez
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown)			No			16b. SOCIAL SECURITY NO			216-46-0173
17. INFORMANT			Norma E. Hansard, Same as # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>									<u>Immediate</u>
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Hypertensive cardiovascular disease</u>									<u>10 yrs</u>
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Thrombosis of renal artery</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. ALTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
12/11/68		<u>Thrombosis renal artery</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year							
		P.M. 19							
21a. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 23, 1969</u> , to <u>Jan 23, 1969</u> , that (I) <u>(did)</u> lost saw the deceased alive on <u>Jan 23, 1969</u> , and that in (my) <u>(did)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(did)</u> (did not) view the body after death									
22b. SIGNATURE			A. Allan Spier, M.D.			DEGREE		22c. DATE SIGNED	
						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		January 24, 1969	
22d. PHYSICIAN'S NAME (Type)			A. Allan Spier, M.D.			22e. ADDRESS		1501 Pentridge Rd., Baltimore, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		Jan. 27, 1969		Moreland Park Cemetery		Baltimore Co., Maryland			
24. FUNERAL DIRECTOR			Wm. Cook-Brooks Towson, 1050 York Road			25a. REGISTRATION NO.		25b. REGISTRAR'S SIGNATURE	
			Towson, Maryland 21204			DATE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top pages, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00402 00398									
Items 10 & 11 Film 109 2/7/69 KK									
1. DECEASED-NAME (Type or print) <b>ELSIE C. HANSEN</b>			2a. DATE OF DEATH 1 Month 29 Day 69 Year			2b. HOUR 3:00 P.M.			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>MAR 5, 1892</b>		6. AGE (In years last birthday) <b>76 YRS</b>		7. UNDER YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>			
10. CITY OR TOWN OF DEATH <b>Baltimore Co.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3607 Langrehr Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>BALTO</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3607 Langrehr Rd.</b>	
14. FATHER'S NAME First <b>William</b> Middle <b>C</b> Last <b>Bode</b>			15. MOTHER'S MAIDEN NAME First <b>Fischer</b> Middle <b>Fischer</b> Last <b>Fischer</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO		17. INFORMANT <b>Robert W. Hansen</b>		Address <b>2201 Argonne Dr #18</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-vascular Disease</b> <b>41</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>—</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour <b>AM</b> Month <b>—</b> Day <b>19</b> Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>February 16, 1954</b> to <b>January 29, 1969</b> , that (I) (we) last saw the deceased alive on <b>January 24, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>W. Grafton Herpsberger</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>January 30, 1969</b>			
22d. PHYSICIAN'S NAME (Type) <b>W. Grafton Herpsberger</b>		22e. ADDRESS <b>214 Medical Arts Bldg.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Feb 1, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon PK</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO</b>			
24. FUNERAL DIRECTOR <b>ES Mae Nalb</b>				ADDRESS <b>301 Frederick Rd #28</b>		25a. REC'D BY REGISTRAR <b>FEB 3 1969</b>		25b. REGISTERED TITLE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR
GUY H. HARE						1- 23 - 69			7:45 P
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. AGE (In years last birthday)	
Male		White		8-7-1900		68 RS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				BALTIMORE Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
TOWSON			St. Joseph's Hospital			Compositor			Newspaper
13a U.S.A. RESIDENCE (Where deceased lived, if instit on Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	3d INS DE CITY, M TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			—		Balto.			3501 St. Paul St.	
4 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MA DEN NAME			First Middle Last
Clarence Hare						Oris D. Long			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO		17 INFORMANT Address				
yes			WW-1		213-03-2438 Mrs. Mildred Naunton-215 Register				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)									19. PROBABLE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonitis, bilateral</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Emphysema</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Arteriosclerotic heart disease</u>									
19a. DATE OF OPERAT ON		19b. CONDITION FOR WHICH OPERAT ON WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>1-22-</u> 19 <u>69</u> , to <u>1-23-</u> 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>1-23-</u> 19 <u>69</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour <input checked="" type="checkbox"/> (and) from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>Gualberto Gokim, Jr. - M.D.</u>					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-23-69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Gualberto Gokim, Jr. - M.D.					7620 York Road, Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		1/27/69		Dulaney Valley Memorial		Baltimore			
24. FUNERAL DIRECTOR		ADDRESS		25a. JURY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Mitchell-Wiedefeld Home-6500 York Rd-21212									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00403

00400

1. DECEASED-NAME (Type or print) First Middle Last <b>MINNIE M Hauptmann</b>			2a. DATE OF DEATH Month Day Year <b>1-6-69</b>			2b. HOUR <b>12:25 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>11-2-83</b>		6. AGE (In years lost birthday) <b>85</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tol give street address) <b>BALT. CO. GEN. HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <b>Md.</b>		13b. CITY OR TOWN <b>BALTIMORE</b>		13c. INSIDE CITY, Y.M.T.S? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>1122 E. Belvedere Ave</b>	
14. FATHER'S NAME First Middle Last <b>Frank Mordeck</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Bertha Bey</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>2160742250</b>		17. INFORMANT <b>William J. Graham</b> Address <b>same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GRAM NEGATIVE SEPSIS.</b> <b>5771</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC &amp; ACUTE PANCREATITIS.</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home farm, street factory) OFFICE BUILDING, ETC.		21f. OCCASION Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-4-1969</b> , to <b>1-6-1969</b> , that (I) (we) lost saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/6/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>[Signature]</b>				22e. ADDRESS <b>Baltimore County Gen. Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>1/9/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>J. Kuck</b>				ADDRESS <b>5305 Harford Road</b>		25a. REC'D BY REGISTRAR <b>JAN 8 1969</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

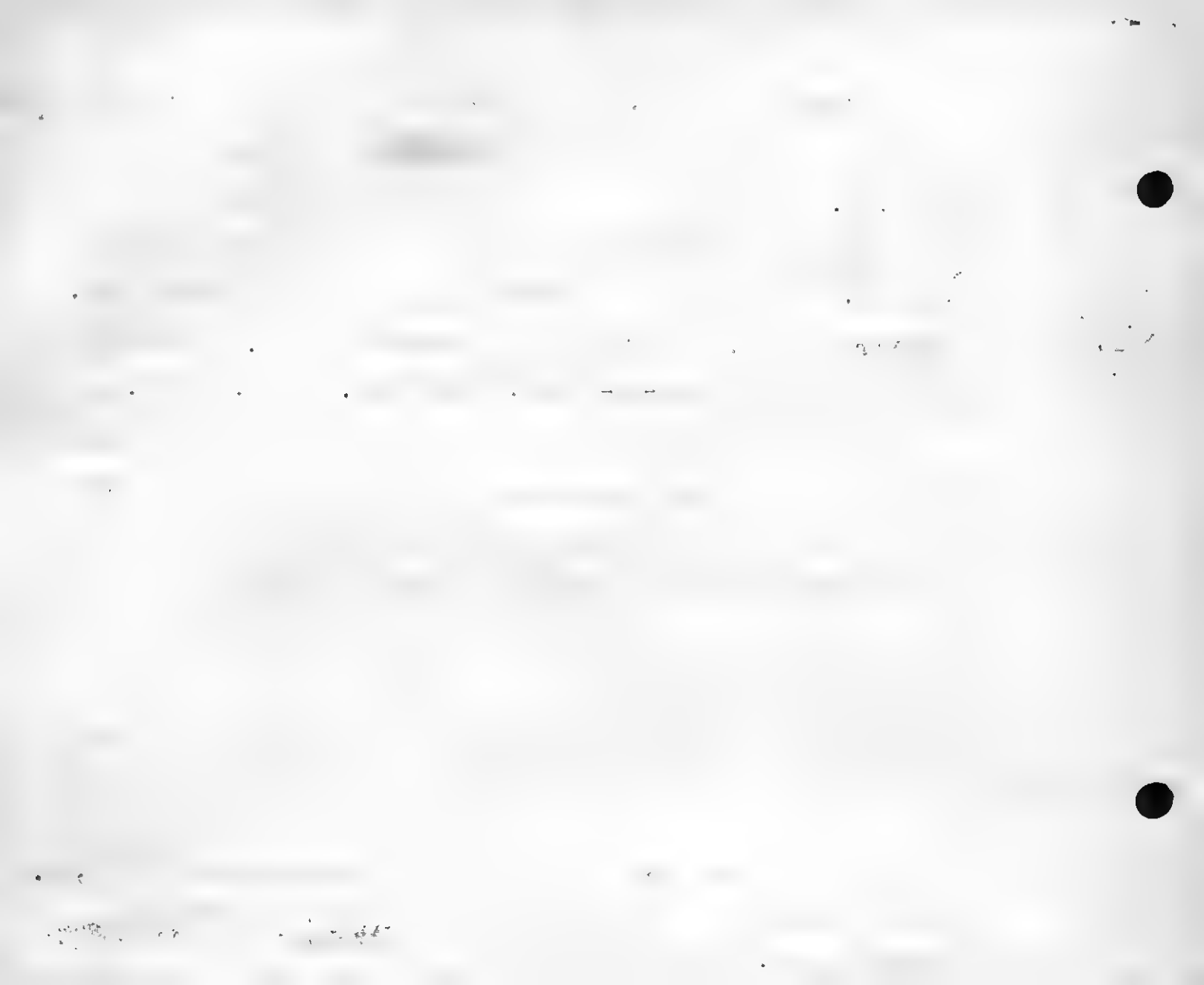
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00400

00401

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Dorothy			A.		Hecht	1 17 69			12p No		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE				66 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
BALTIMORE, MD.		USA				Baltimore			Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Pikesville		Professional House		SALESLADY		RETAIL					
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.		-		Baltimore				Marlborough Apts.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Leonard			B.		Hecht	JENNIE			F.		Friedenwald
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
NO			219-12-8352			MR. JOSEPH HECHT, 1010 ST. PAUL ST.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus cerebral vascular accident</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 31</u> , 19 <u>65</u> , to <u>Jan 17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Jan 16</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>David I. Miller M.D.</u>						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>1-17-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>David I. Miller</u>						22e. ADDRESS <u>9115 Reisterstown Rd Owings Mills, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL			1-19-69		BALTIMORE HEBREW		BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>						25a. RECEIVED BY REGISTRAR <u>JAN 22 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI DEATH MATED			2b HOUR					
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (in years not birthday)		7 UNDER 1 YEAR		7c DATE PRONOUNCED DEAD			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			2d HOUR			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a LSUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
13a USLA. RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?			16b SOCIAL SECURITY NO			17 INFORMANT		
First Middle Last			First Middle Last			Yes, no, or unknown			(If yes give war or dates of service)			ADDRESS		
Jacob			Hedrick			No			213-05-7275			Mrs John D. Wanker 8379 Norven Road 21234		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolism at</u>														
DUE TO, OR AS A CONSEQUENCE OF <u>fractured hip at - intertrochanteric</u>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Atherosclerotic Cardiovascular disease; Myocardial Infarction; Emphysema</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town					
			Home			7839 Wendover Ave			Baltimore Md					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED								
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			1-19-69								
JOHN C. Hyde MD			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			7527 Belair Rd 21236					
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
Cremation			1-21-1969			Greenmount Cemetery			Baltimore Md					
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
Lassahn Funeral Home			7401 Belair Rd.			DATE JAN 23 1969			Charles Judge					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00403

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF DEATH		<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year	2b. HOUR
EDWARD Allan HEISLER					DATE MATED <input checked="" type="checkbox"/>		19	M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7. UNDER 1 YEAR	8. FINGER 24 HRS	2c. DATE PRONOUNCED DEAD	
male	white	Aug. 19, 1916		59 YRS	MONTHS	HOURS	Min	2d. HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR
Phila. Pa.		USA				Baltimore		9:30 A. M
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Govans		6807 Blenheim Rd.		chemical engineer				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland		Baltimore		Govans		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6807 Blenheim Rd.
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle
John C. Heisler					Jennie Waters			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		
no		222-09-2985		Mr. Gene Heisler		115 Stanmore Road #21212		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage Originating from</u>								
<u>Esophageal Varices due to Cirrhosis</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>								
(c) <u></u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
		HOUR A.M. P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		
						County		
						State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE		Werner D. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		1/7/69		
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
				ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
cremation		1/9/69		Greenmount		Balto. Md.		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		
Mitchell-Wiedefeld Home				6500 York Rd. #21212		DATE		
						25b. REGISTRAR'S SIGNATURE		
						JAN 14 1969		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 113  
30M REV 1-64

00408

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00404

1. DECEASED NAME (Type or print) <b>Edna E Hellwig</b>			2a. DATE OF DEATH <b>JAN 24 69</b> Month Day Year			2b. HOUR <b>1:20</b> P. M.				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 13, 1886</b>		6. AGE (In years last birthday) <b>82</b> YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.				
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Chesapeake Manor</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Fullerton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>4 Fullerton Heights Avenue</b>	
14. FATHER'S NAME First Middle Last <b>Charles Lauman</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth Meeth</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (a, or unknown) (If yes give war or dates of service) <b>No.</b>			16b. SOCIAL SECURITY NO		17. INFORMANT Address <b>Mrs Grace E. Warner 19 Cedar Avenue 4</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Atherosclerotic Cardiovascular</b> (c) <b>Chronic Renal Degeneration</b>								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <b>13 hrs</b> <b>undet.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (th) (his) (hospital) attended the deceased from <b>1961</b> to <b>1-24</b> , 1969, that (I) (we) last saw the deceased alive on <b>1-24</b> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <b>John C. Hyle</b>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>1-24-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>JOHN C Hyle</b>					22e. ADDRESS <b>2527 Belair Rd Balto 21236 Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1-27-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md.</b>				
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road 21236</b>					25a. REC'D BY REGISTRAR <b>JAN 27 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #23b, Film 6409 1/31/69 km									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
WILFORD			LANE			HENDERSON			Month Day Year JANUARY 19, 1969
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		7. UNDER YEAR MONTHS DAYS	
MALE		NEGROID		MARCH 6, 1900		68 YRS.		7:30 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
S.C.		U.S.A.				BALTIMORE		FORT HOWARD	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work on life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		13a. CITY OR TOWN		13b. COUNTY	
HOSPITAL VETERANS ADMINISTRATION		STEVEDORE		LONGSHOREMAN		BALTIMORE		BALTIMORE	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. USUAL CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND				BALTIMORE				1940 WEST FRANKLIN STREET	
14 FATHER'S NAME First Middle Last			15. MOTHER'S M A D E N NAME First Middle Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO
ANTHONY			HENDERSON			LULA			215 01 7989
YES			WWII			CLINICAL RECORDS, VA HOSP, FT HOWARD, MD			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CERE BRO - VASCULAR ACCIDENT									
4369 DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROSIS, GENERALIZED									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
URINARY TRACT INFECTION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory office building etc)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 12 4 68, 19, to 1 19 69, 19, that (X) (we) last saw the deceased alive on 1 19 69, 19, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.									
22b. SIGNATURE Alfonso A. Lopez				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 1 19 69			
22d. PHYSICIAN'S NAME (Type) ALFONSO A. LOPEZ, M.D.				22e. ADDRESS VETERANS ADMIN HOSP, FT HOWARD, MARYLAND					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE Jan. 23, 1969		23c. NAME OF CEMETERY OR CREMATORY BALTO NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD		23e. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR JAN 27 1969		25b. REGISTRAR'S SIGNATURE			
PHILLIPS FUNERAL HOME, 1727 N MONROE ST, BALTO, MD									



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00406

1 DECEASED NAME (Type or print) First Middle Last <b>Ethel Delois Henson</b>			2a. DATE OF DEATH Month Day Year <b>1 20 69</b>			2b. HOUR <b>6:56 AM</b>			
3 SEX <b>Female</b>	4 RACE <b>Negro</b>		5 DATE OF BIRTH <b>12-24-41</b>		6 AGE (In years last birthday) <b>27 YRS</b>		7 UNDER YEAR MONTHS DAYS <b>IF UNDER 24 HRS. HOURS MIN.</b>		
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Baltimore</b> Md			
10 CITY OR TOWN OF DEATH <b>Owings Mills</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rosewood State Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>None</b>		12b KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>923 Whatcoat St.</b>	
14 FATHER'S NAME First Middle Last <b>Samuel Henson</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Caroline Blake</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b SOCIAL SECURITY NO <b>None</b>		17 INFORMANT Address <b>Caroline Henson 923 N. Whatcoat St.</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia.</b> <b>7431</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Microcephaly, quadriplegia.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Mental retardation, Epilepsy.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a I certify that <del>(he)</del> (this hospital) attended the deceased from <b>3-6-68</b> , 19 <b>68</b> , to <b>1-20</b> , 19 <b>69</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>1-20</b> , 19 <b>69</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.									
22b SIGNATURE <b>Massoud Kaye</b>				DEGREE <b>MASSOUD KAYE</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <b>1-20-69</b>	
22d PHYSICIAN'S NAME (Type) <b>MASSOUD KAYE</b>				22e ADDRESS <b>Rosewood State Hospital, Owings Mills Md-8117</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>1/23/69</b>		23c NAME OF CEMETERY OR CREMATORY <b>Baltimore Natl. Cem.</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24 FUNERAL DIRECTOR <b>Verdon R. Bailey</b>				ADDRESS <b>1348 N. Calhoun</b>		25a REG'D BY REGISTRAR <b>21 1969</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
ELMER			T. HERZBERG			Month Day Year 1 - 31 - 69		5:40 P M	
3 SEX		4. RACE		5 DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS HOURS MIN	
Male		White		6-7-1902		66 YRS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		U.S.A.				BALTIMORE			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address)		12a. OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		St. Joseph's Hospital		Foreman		Steel Mill			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Essex		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		832 Dorsey Ave., 21221	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Fredrick W. Herzberg			Marie Wanner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT		Address		
No			213 07 5353		Bernard Herzberg		Same		
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Acute myocardial infarction</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF <u>Thrombotic occlusion of left coronary artery</u> (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>1-30-69</u> , 19 <u>69</u> , to <u>1-31-</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>1-31-</u> 19 <u>69</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (and we) view the body after death									
22b. SIGNATURE <u>Cilliani</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED		
							Feb. 1, 1969		
22d. PHYSICIAN'S NAME (Type) <u>Ines Cilliani, M. D.</u>					22e. ADDRESS				
					<u>7620 York Road, Towson, Md. 21204</u>				
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/4/69		Holly Hill Memorial Gardens		Baltimore Co., Md.			
24. FUNERAL DIRECTOR <u>Bruzdinski</u> ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Bruzdinski Funeral Home 1407 Eastern Ave.					FEB 4 1969		<u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

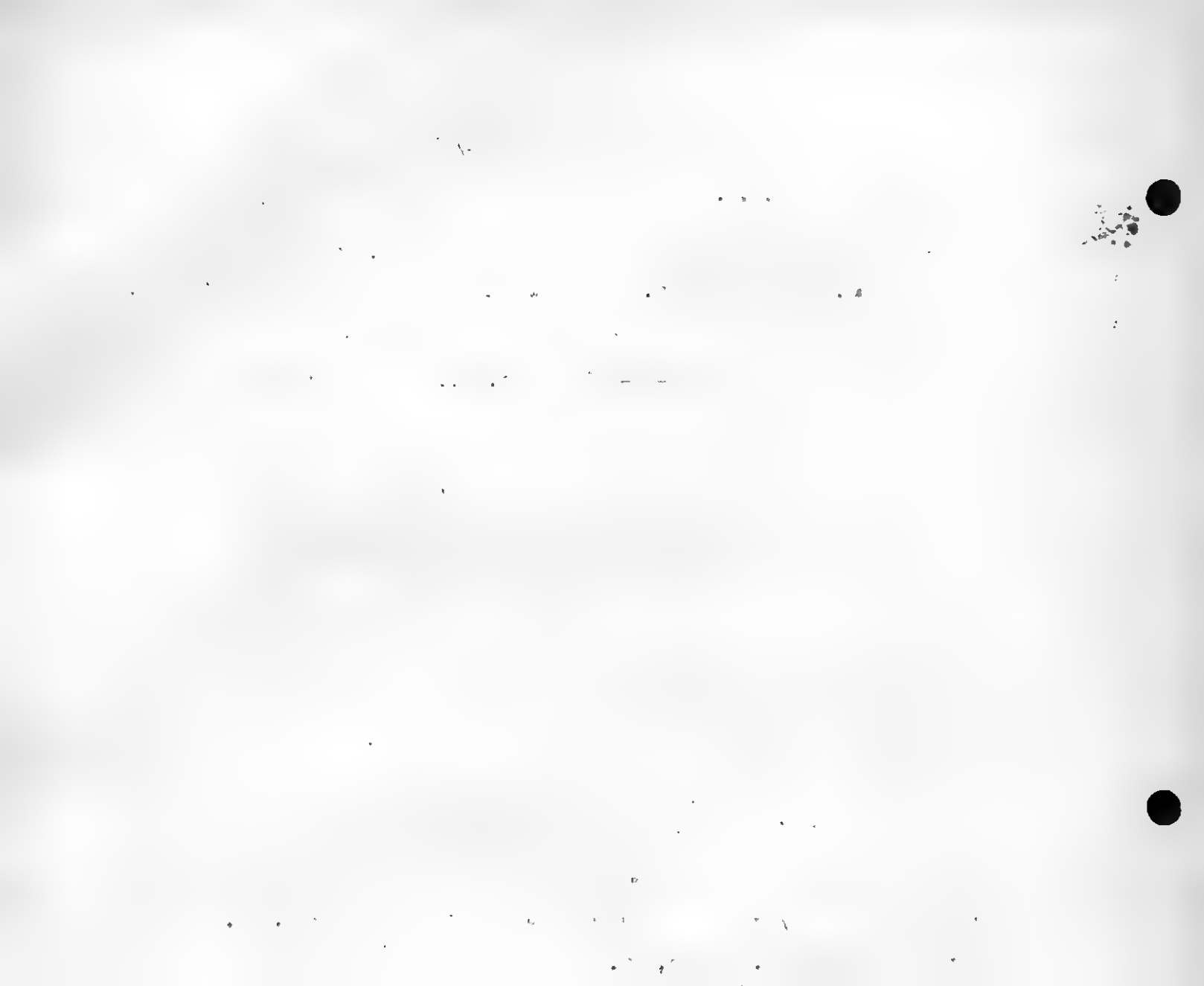
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

0041

00408

1. DECEASED NAME (Type or print) <b>ERIC KARL HESSE</b>			2a. DATE OF DEATH 1 Month 30 Day 69 Year			2b. HOUR 12:10 <sup>AM</sup>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7/31/1900</b>		6. AGE (In years last birthday) <b>68</b> YRS			
7a. BIRTHPLACE (State or foreign country) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore,</b> Md			
10. CITY OR TOWN OF DEATH <b>Baltimore, Maryland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GBMC</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Timonium</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET AND NUMBER <b>1814 Blakefield Circle</b>									
14. FATHER'S NAME <b>Emil Hesse</b>			15. MOTHER'S MAIDEN NAME <b>Elizabeth Ruehle</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>055-12-5515A</b>		17. INFORMANT <b>Mrs. Kate Hesse</b> same		Address		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fresh and old cerebral emboli</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Mural thrombus, left atrium</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atrial fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/13/</b> , 19 <b>69</b> , to <b>1/30/</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1/30</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <b>Charles C. Brown, M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/30/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Charles C. Brown, M.D.</b>				22e. ADDRESS <b>Greater Baltimore Medical Center</b>					
23a. BURIAL, CREMATION, or other disposition <b>Cremation</b>		23b. DATE <b>1/31/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>				ADDRESS		25a. RECEIVED BY REGISTRAR <b>FEB 4 1969</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



# FOR STATE HEALTH DEPT.

TO FURNISH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00413

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00409

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
HAYWARD			HEUBECK			Month Day Year			31 38 M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
MALE	CAU	4-28-27	4 yrs	MONTHS	DAYS	HOURS	MIN	January 29 Year 1969			38 M
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH		
Maryland			USA			NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			BALTIMORE		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			GREAT BALT MED CENT.			PAINT Manufacturer			Same		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md			—			Balt			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
611 Edgevale Rd			First Middle Last			First Middle Last			Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		
			Clarence D. Heubeck Sr			Murtle I Maisel			16b. SOCIAL SECURITY NO		
									216 20 2140		
									17. DECEASED'S ADDRESS		
									Mary Grace Heubeck Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											Sudden
IMMEDIATE CAUSE (a) 16.9 Pulmonary Embolism											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Fracture of C-4-C-7 and											11 Day
DUE TO, OR AS A CONSEQUENCE OF											
(c) Failed to take necessary blood											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY?			
1/21/69				fracture C-4-C-7 Damage to Spinal Cord				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b. TIME OF INJURY Month Day Year				21c. HOW INJURY OCCURRED (Enter notice of injury in Part 1 or Part 2, item 18)			
				8:53 AM 1/18/69				Ran off Highway Struck Pole			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION (Street or R.F.D. No. City or Town County)			
				Interstate Beltway				Beltway #695 North of Joppa Rd outside			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:											
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				1/24/69			
CHARLES O'DONNELL, M.D.				DEPUTY MEDICAL EXAMINER							
				ADDRESS (Street, city, town, or county)							
23. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			2-1-69			Druid Ridge Cem			Pikesville Balto Co MD		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Burger Funeral Home Balto Md						DATE FEB 4 1969			Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last ELLA F NICKMAN			2a DATE OF DEATH Month 1 Day 23 Year 69		2b HOUR 5 P.M.
3. SEX F	4. RACE W		5. DATE OF BIRTH April 20 1887		6 AGE (in years last birthday) 80 YRS.
7a BIRTHPLACE (State or foreign country) Md.	7b CIT ZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Cockeysville		11 NAME OF HOSP TAL OR INSTITUTION (If not in hospital give street address) Masonic Home		12a JSAL OCCUPATION (Kind of work done during most of working life, even if retired)	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b COUNTY Frederick	13c CITY OR TOWN Hagerstown	13d INS OR CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER
14. FATHER'S NAME First Middle Last WARNER S. POOLE			15 MOTHER'S MA DEN NAME First Middle Last ELLA 1 ORME		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16b SOCIAL SECURITY NO 216-16-2288	17 INFORMANT Masonic Home Records		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4: Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerotic Vas. Heart Dis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b. COND.TION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from Dec. 1, 1969, to Jan. 23, 1969, that (I) (we) last saw the deceased alive on Jan. 23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Carl F. Benson M.D.		22c. DATE SIGNED Jan. 23 1969		22d. PHYSICIAN'S NAME (Type) Carl F. Benson M.D.	
22e. ADDRESS 5111 York Rd Balto. Md 21212					
23a. BURIAL, CREMATON, REMOVAL (Specify)		23b DATE 1-27-1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION (City or Town) (County) (State) Washington, D.C.					
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		ADDRESS 1050 York Road 21204		25a. REC'D BY REGISTRAR DATE JAN 27 1969	
25b REGISTRAR'S SIGNATURE Charles Jones					



## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Mary</b> <sup>First</sup> <b>Rebecca</b> <sup>Middle</sup> <b>Hinder</b> <sup>Last</sup>			2a. DATE OF DEATH <b>1</b> Month <b>30</b> Day <b>1969</b> or			2b. HOUR <b>3P</b> M					
3. SEX <b>F.</b>		4 RACE <b>W.</b>		5 DATE OF BIRTH <b>7/9/1872</b>		6 AGE (In years last birthday) <b>96</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto.</b>					
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Towson Convalescent Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>at home</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Long Green</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Manor Road</b>		
14 FATHER'S NAME <sup>First</sup> <b>Frederick</b> <sup>Middle</sup> <b>Hinder</b> <sup>Last</sup>			15 MOTHER'S MAIDEN NAME <sup>First</sup> <b>Katherine</b> <sup>Middle</sup> <b>Fielding</b> <sup>Last</sup>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO. <b>217-56-5110</b>		17. INFORMANT <sup>Address</sup> <b>Miss Helen Hinder 101 W. Monument St.</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 10, 1968</b> , to <b>Jan 30, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan 30, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Laurence C. Post M.D.</b>						DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/31/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Laurence Post</b>						22e. ADDRESS <b>M.D.</b>		22f. ADDRESS <b>6805 York Rd. Balto. Md.</b>			
23a. BURIAL CREMATION, <b>Burial</b>			23b. DATE <b>2/1/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Long Green, Md.</b>		
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>						25a. REC'D BY REGISTRAR DATE <b>JAN 31 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR  
45M  
1/13/69

00410										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00412									
Item 6 Film 3408 1/15/69 kk										CERTIFICATE OF DEATH																			
1 DECEASED NAME (Type or print)					First <b>ERNEST</b>					Middle <b>HENRY</b>					Last <b>HINRICHES, SR.</b>					2a DATE OF DEATH Month <b>1</b> Day <b>9</b> Year <b>69</b>					2b HOUR <b>9:15</b> P M				
3 SEX <b>MALE</b>					4 RACE <b>WHITE</b>					5 DATE OF BIRTH <b>11-16-1891</b>					6 AGE (In years last birthday) <b>76</b> YRS					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					IF UNDER 24 HRS HOURS MIN				
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>					7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>BALTIMORE</b>										Md				
10. CITY OR TOWN OF DEATH <b>TOWSON</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hospital</b>					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b KIND OF BUSINESS OR INDUSTRY														
13a USUAL RESIDENCE (Where deceased admission) STATE <b>Maryland</b>					ved, if institution Residence before 13b COUNTY <b>Baltimore</b>					13c CITY OR TOWN <b>Riderwood</b>					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e STREET AND NUMBER <b>1408 Walnut Hill Lane, 04</b>									
14. FATHER'S NAME First <b>JOHN</b>					Middle <b>HINRICHES</b>					Last <b>ELLA</b>					15. MOTHER'S MAIDEN NAME First <b>ELLA</b>					Middle <b>GAIL</b>					Last <b>GAIL</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>YES</b>					(If yes give war or dates of service) <b>WW 1</b>					16b SOCIAL SECURITY NO. <b>J1</b> <b>216-46-1862</b>					17 INFORMANT: <b>son</b> <b>Dr. E. Henry Hinrichs, Jr. 1808 Circle Rd.</b>										Address <b>Ruxton, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Massive acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Bilateral pneumonia</b>																													
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED										20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e PLACE OF INJURY (At home farm street, factory) OFFICE BUILDING ETC										21f LOCATION Street or R.F.D. No City or Town County State														
22a. I certify that (X) (this hospital) attended the deceased from <b>12-28-</b> , 19 <b>68</b> , to <b>1-9-</b> , 19 <b>69</b> , that (X) (we) last saw the deceased alive on <b>1-9-</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																													
22b SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>										DEGREE <b>M.D.</b>					ATTENDING <input type="checkbox"/> MED <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS DIRECTOR PHYS					22c DATE SIGNED <b>1-10-69</b>									
22d PHYSICIAN'S NAME (Type)										22e ADDRESS <b>7620 York Road, Towson, Md. 21204</b>																			
23a BURIAL, CREMATION, REMOVAL (Specify)					23b DATE <b>JAN. 13/1969</b>					23c NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>					23d LOCATION (City or Town) (County) (State) <b>Pikesville, Balto. Co., Md.</b>														
24 FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO. 108 W. North Av., Balto. 1</b>										ADDRESS					25a REC'D BY REGISTRAR <b>JAN 13 1969</b>					25b REGISTRAR'S SIGNATURE <b>James Judge</b>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

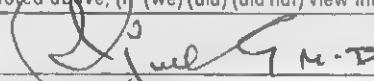

1 DECEASED NAME (Type or print) <b>Chester Rodney Hobbs</b>			2a DATE OF DEATH Month <b>January</b> Day <b>18</b> , Year <b>1969</b>		2b HOUR <b>6 A: M</b>
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>July 18, 1884</b>		6 AGE (In years last birthday) <b>84 YRS</b>	7 UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>United States</b>		8- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH <b>Baltimore,</b>			10 CITY OR TOWN OF DEATH <b>Catonsville,</b>		
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Shangri-La Nursing Home</b>			12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Farming</b>
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Baltimore,</b>	13c CITY OR TOWN <b>21207</b>	13d STREET AND NUMBER <b>3611 Essex Road,</b>	
14 FATHER'S NAME First <b>Clayton</b> Middle <b>Wilson</b> Last <b>Hobbs</b>			15 MOTHER'S MAIDEN NAME First <b>Josephine</b> Middle <b>Victoria</b> Last <b>Gilbert</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>No</b>		16b SOCIAL SECURITY NO <b>221-24-8473</b>		17 INFORMANT <b>Ruth Hobbs Chopin</b> Address <b>3611 Essex Rd.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last)					(b) <b>Hypertensive cardiovascular disease</b> <b>10 years</b>
(c) <b>Arteriosclerotic cardiovascular disease</b> <b>10 years</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a I certify that (I) <del>(the hospital)</del> attended the deceased from <b>1963</b> to <b>January</b> , 19 <b>69</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>January 15</b> , 19 <b>69</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (aid) <del>(saw)</del> view the body after death					
22b SIGNATURE <b>Millard T. Traband, Jr.</b>				22c DATE SIGNED <b>Jan. 17, 1969</b>	
22d PHYSICIAN'S NAME (Type) <b>Millard T. Traband, Jr. M.D.</b>				22e ADDRESS <b>1811 N. Rolling Rd. Balt. Md. 21207</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>1/18/1969</b>		23c NAME OF CEMETERY OR CREMATORY <b>Prospect Cemetery</b>	
23d LOCATION (City or Town) (County) (State) <b>Frederick Co., Md.</b>					
24 FUNERAL DIRECTOR <b>C. M. Waltz, Box 241, Sykesville, Md.</b>				25a REC'D BY REGISTRAR <b>20 1969</b>	
				25b REGISTRAR'S SIGNATURE <b>William A. Judge</b>	

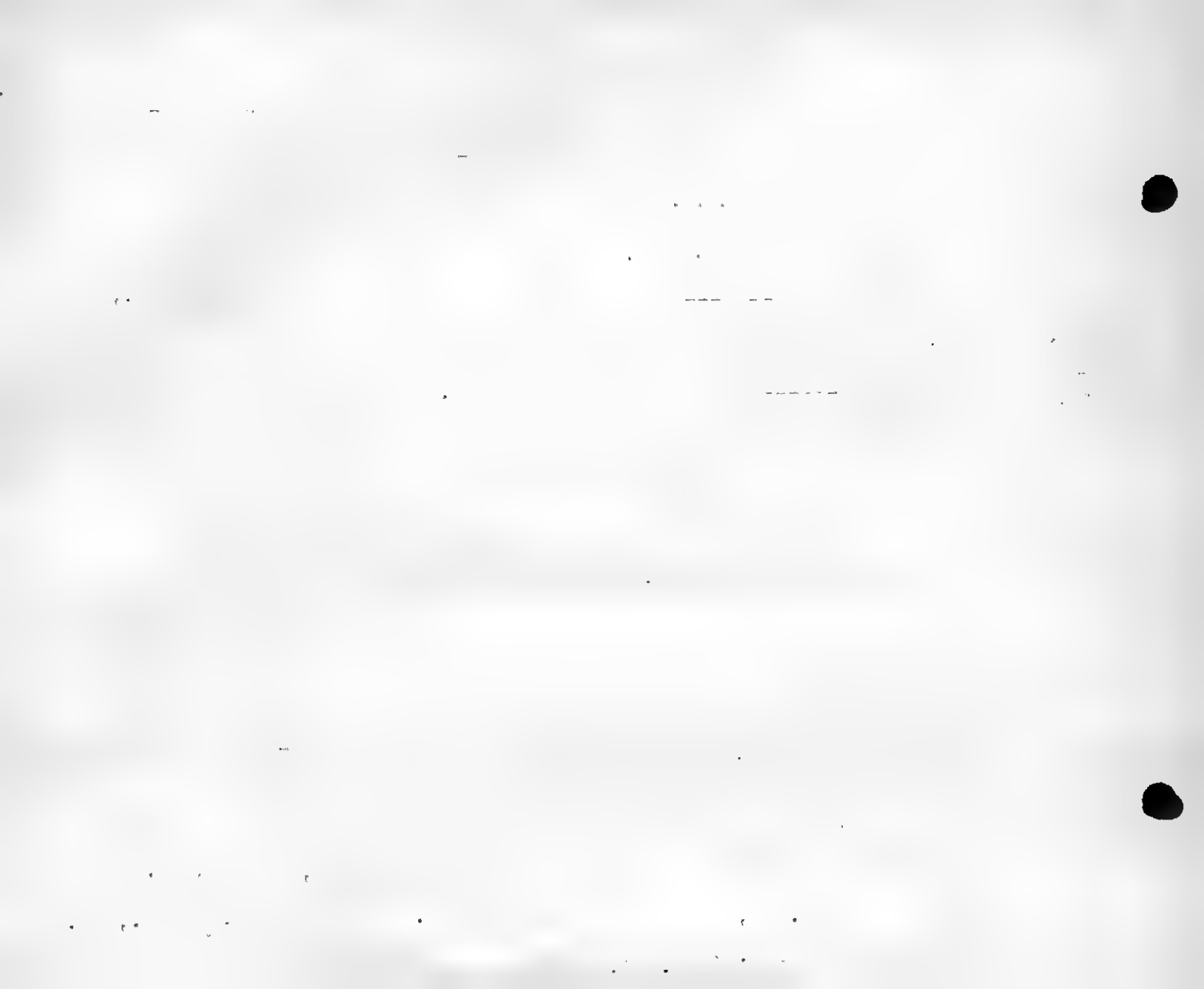


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> <span>00418</span> <span>CERTIFICATE OF DEATH</span> <span>00414</span> </div>									
1 DECEASED NAME (Type or print)			2a DATE OF DEATH			2b HOUR			
<div style="display: flex; justify-content: space-between;"> <span>First</span> <span>Middle</span> <span>Last</span> </div> <b>LOUIS ALBERT HOFF</b>			<div style="display: flex; justify-content: space-between;"> <span>Month</span> <span>Day</span> <span>Year</span> </div> <b>1- 22 - 69</b>			<div style="display: flex; justify-content: space-between;"> <span>8:25</span> <span>P</span> </div>			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR	
<b>MALE</b>		<b>WHITE</b>		<b>7-11-1896</b>		<b>72</b> YRS		<div style="display: flex; justify-content: space-between;"> <span>MONTHS</span> <span>DAYS</span> </div>	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
<b>Maryland</b>		<b>U.S.A.</b>				<b>BALTIMORE</b> Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUA. OCCUPAT. ON (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
<b>TOWSON</b>		<b>St. Joseph's Hospital</b>		<b>Plumber</b>		<b>Plumbing</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
<b>Maryland</b>		<b>-----</b>		<b>Baltimore</b>		<b>YES</b>		<b>6819 McClean Blvd., 21234</b>	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
<div style="display: flex; justify-content: space-between;"> <span>First</span> <span>Middle</span> <span>Last</span> </div> <b>John Hoff</b>			<div style="display: flex; justify-content: space-between;"> <span>First</span> <span>Middle</span> <span>Last</span> </div> <b>Amelia (unknown)</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT Address			
<b>no</b>			<b>215-03-7154</b>			<b>Louis N. Hoff 6819 McClean Blvd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory insufficiency</b>									
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <b>chronic lung disease</b>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<b>1) Bronchogenic carcinoma, left lung; 2) Congestive heart failure</b>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		<div style="display: flex; justify-content: space-between;"> <span>HOUR A.M.</span> <span>Month</span> <span>Day</span> <span>Year</span> </div> <b>19</b>							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1-21</b> , 19 <b>69</b> , to <b>1-22</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>1-22</b> , 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death									
22b SIGNATURE						DEGREE		22c DATE SIGNED	
						<div style="display: flex; justify-content: space-between;"> <span>ATTENDING PHYS</span> <span>MED DIRECTOR</span> <span>STAFF PHYS</span> </div> <b>1/23/69</b>			
22d PHYSICIAN'S NAME (Type)						22e ADDRESS			
<b>Reynaldo Orjuela-Gomez, M.D.</b>						<b>7620 York Road, Towson, Md. 21204</b>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
<b>Burial</b>		<b>Jan. 25, 1969</b>		<b>Holy Redeemer Cem.</b>		<b>Belair Rd. Balto., Md.</b>			
24. FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
<b>Dippel Brothers Inc. 7110 Belair Road Balto. Md. 21206</b>						<b>JAN 27 1969</b>			



00419

00415

1 DECEASED NAME (Type or print) <b>Hermine</b>		First Middle Last <b>B. HOFFMANN</b>		2a. DATE OF DEATH Month Day Year <b>1 15 1969</b>		2b. HOUR <b>620 P.M.</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>December 13, 1888</b>		6 AGE (In years last birthday) <b>80</b> YRS	
7a BIRTHPLACE (State or foreign country) <b>Austria</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Baltimore,</b>	
10 CITY OR TOWN OF DEATH <b>Towson</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE <b>Maryland</b>		13b COUNTY <b>Baltimore</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INS DE CITY LIM TSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>1241 E. Belvedere Ave.</b>		14 FATHER'S NAME First Middle Last <b>Josef Bachyne</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16b SOCIAL SECURITY NO. <b>215-05-2271</b>		17 INFORMANT <b>Mrs William G. Lumpkin</b>		Address <b>6124 Haddon Hall Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Gram negative septicemia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute pyelonephritis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5901</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Carcinoma of head of pancreas</b>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natlly medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (X) (this hospital) attended the deceased from <b>1/1/</b> , 19 <b>69</b> , to <b>1/15/</b> , 19 <b>69</b> , that (X) (we) last saw the deceased alive on <b>1/15/</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (d) (d) view the body after death.							
22b SIGNATURE <b>Christina Feliciano, M.D.</b> DEGREE				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED <b>1-16-69</b>	
22d PHYSICIAN'S NAME (Type) <b>Christina Feliciano, M.D.</b>				22e ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>1/18/69.</b>		23c NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a RECEIVED BY <b>JAN 17 1969</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
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00420

## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
GERTRUDE			S.		HOGGARD	Month 1 Day 17 Year 1969			1:20p M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.
Female		Caucasian		June 2, 1892.		76 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
North Carolina		USA				Baltimore Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Towson			Greater Balto. Med. Center			housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto.		Balto.				1900 Wilson Pt. Road	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last	
William A. Savage						Gattie Savage				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT			Address		
No					Mrs. Margaret A. Sparwasser			(Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u>										
4121 DUE TO, OR AS A CONSEQUENCE OF										
(Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last)										
(b) <u>Arterioneurosclerosis</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Hypertensive arteriosclerotic cardiovascular disease</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/16, 1968</u> , to <u>1/17, 1969</u> , that (I) (we) last saw the deceased alive on <u>1/17, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Charles C. Brown, M.D.</u>						DEGREE		22c. DATE SIGNED		
						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				1/17/69.
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
Charles C. Brown, M. D.						Greater Baltimore Medical Center				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		1/20/69.		Moreland Memorial Cem.		Baltimore, Md.				
24 FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck, Inc. Balto. Md. 21214						DATE JAN 20 1969		<u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)



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VR A-1  
30M RE-1-1-69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

0042

00417

1. DECEASED-NAME (Type or print) <b>CARRIE GANDEE Holt</b>			2a. DATE OF DEATH Month <b>JAN.</b> Day <b>19</b> Year <b>1969</b>			2b. HOUR <b>12:10 PM</b>					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>Dec. 8, 1888</b>		6. AGE (in years last birthday) <b>80</b> YRS.		7. UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Baltimore</b>			Md.		
10 CITY OR TOWN OF DEATH <b>Randallstown</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chapel Hill Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Circle Drive</b>			
14. FATHER'S NAME First <b>George</b> - Middle <b>Gandee</b> Last <b>Holt</b>			15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mr. James Holt</b>		Address <b>Sykesville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY INFARCTION,</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS.</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.C.V.D.</b>										<b>10 YRS.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>DIABETIS MEL.</b>										<b>10 YRS.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>BED RIDDEN RHEUMATOID OSTEOARTHRITIS</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1956</b> , to <b>1-19</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1-19</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>R. V. Houck, Jr. M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1-21-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>R. V. Houck, Jr.</b>				22e. ADDRESS <b>Sykesville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-22-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springfield Cemetery</b>		23d. LOCATION (City or Town) <b>Sykesville</b>		County <b>Md.</b>		State <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>				ADDRESS <b>Sykesville, Md.</b>		25a. RECEIVED BY REGISTRAR DATE <b>JAN 23 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Richard S. Jones</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in duplicate, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
45M - 1-29

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
0042~						00418					
1 DECEASED NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
First Middle Last						Month Day Year			M		
Blossie RIVERS HOUCK.						1 27 69					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
F		W.		8-4-76		92 YRS.		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
md.		U. S.				Baltimore, Md					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			
Randallstown.				Balt. County Gen. Hosp.				Housewife.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN			
md.				Baltimore				Randallstown.			
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last				16b SOCIAL SECURITY NO			
John Hartman.				Margaret Kelly.				213-16-3284-F2			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				17 INFORMANT				Address			
No				Chart Mrs. Bossie E. Holtman				8823 Liberty Rd. 31133			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY emboli										HOURS	
4510 DUE TO, OR AS A CONSEQUENCE OF (b) Thrombosis of veins - probably legs										HOURS - days	
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) stating the underlying cause last										App. 10 days	
DUE TO, OR AS A CONSEQUENCE OF (c) RE HIP Fracture -											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Early Bronchopneumonia											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		19 P.M.									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)							
Simon Calle, MD		1-27-69		SIMON CALLE, M.D.							
22e ADDRESS		22f ADDRESS									
Baltimore Co. Gen Hosp.		Baltimore Co. Gen Hosp.									
23a BURIAL, CREMATION, OR OTHER DISPOSITION		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		23e REGISTRAR'S SIGNATURE			
Burial		Jan. 30, 69		Mt. Olivet Cemetery		Frederick Maryland Fredrick Co/		Charles Judge			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		DATE			
								JAN 29 1969			
Loring Byers Chapel 8728 Liberty Rd. 21133											



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00420

00419

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pikesville</b>		c. LENGTH OF STAY IN 1b <b>Pikesville 8</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7004 Plymouth Rd., Pikesville, Md.</b>		d. STREET ADDRESS <b>7004 Plymouth Rd.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Mamie Agnes Howser</b>		4 DATE OF DEATH Month Day Year <b>January 3, 1969</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 29, 1879</b>
9 AGE (In years lost birthday) <b>89 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>10 15 00 00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob J. Oster</b>		14. MOTHER'S MAIDEN NAME <b>Catherine</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Gertrude Glendenning</b>		Address <b>Pikesville 8, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4100 Coronary Thrombosis</b> DUE TO (b) <b>Arterio Sclerotic Cardio Vascular Disease</b> DUE TO (c) <b>15 gm.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 15 00 00</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>2/10</b> , 19 <b>69</b> , to <b>1/3</b> , 19 <b>69</b> , that (1) (we) lost the deceased alive on <b>1/3</b> , 19 <b>69</b> , and that death occurred at <b>130A M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Joseph E. Lawka, M.D.</b>		22b. DATE SIGNED <b>1/4/69</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH E. LAWKA, M.D.</b>		22d. ADDRESS <b>679 Washington Blvd Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 6, 1969</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>Laurel Funeral Home Pikesville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 6 1969</b>	
		25b. REGISTRAR'S SIGNATURE <b>James J. George</b>	

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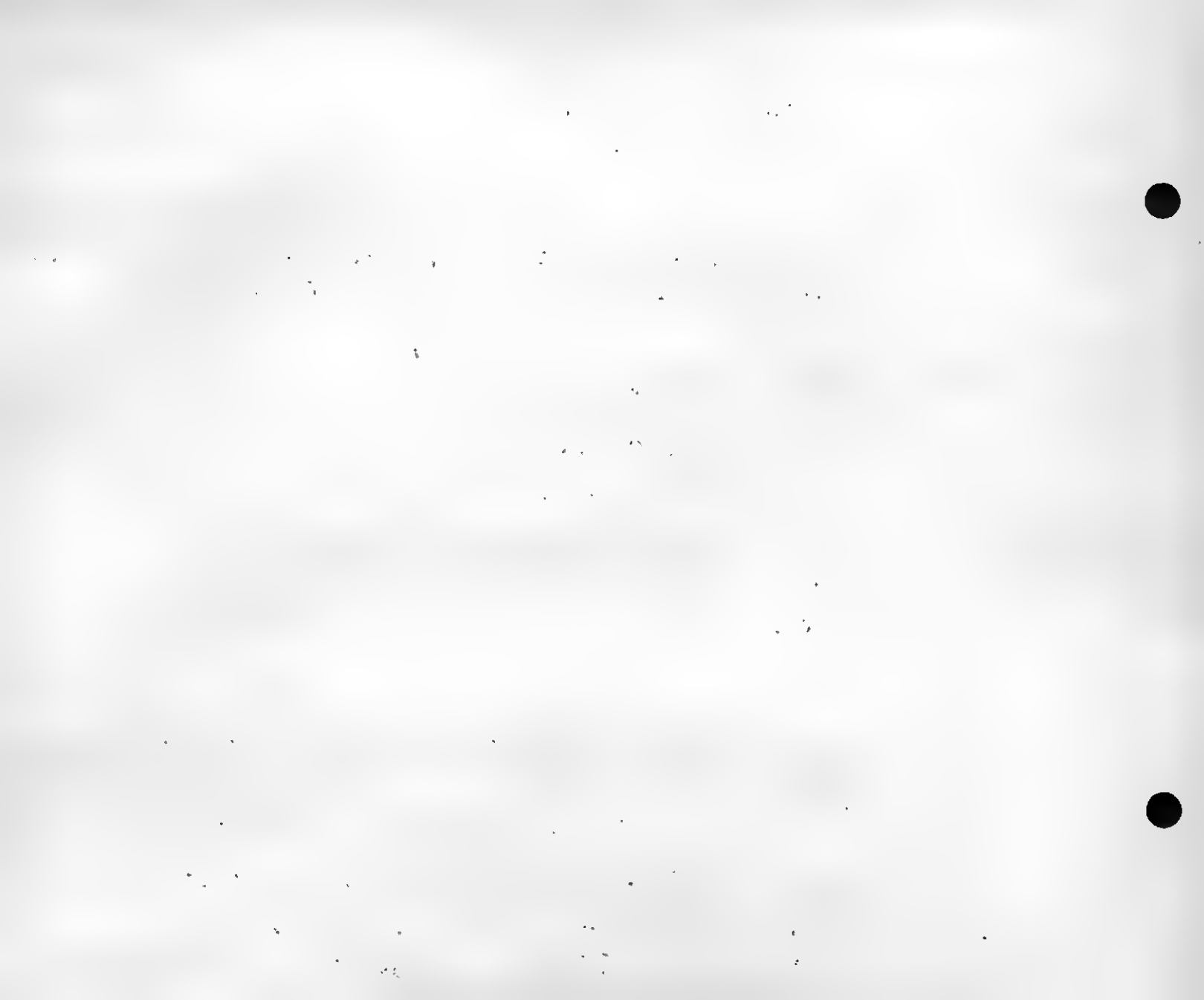
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VR 11-68  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

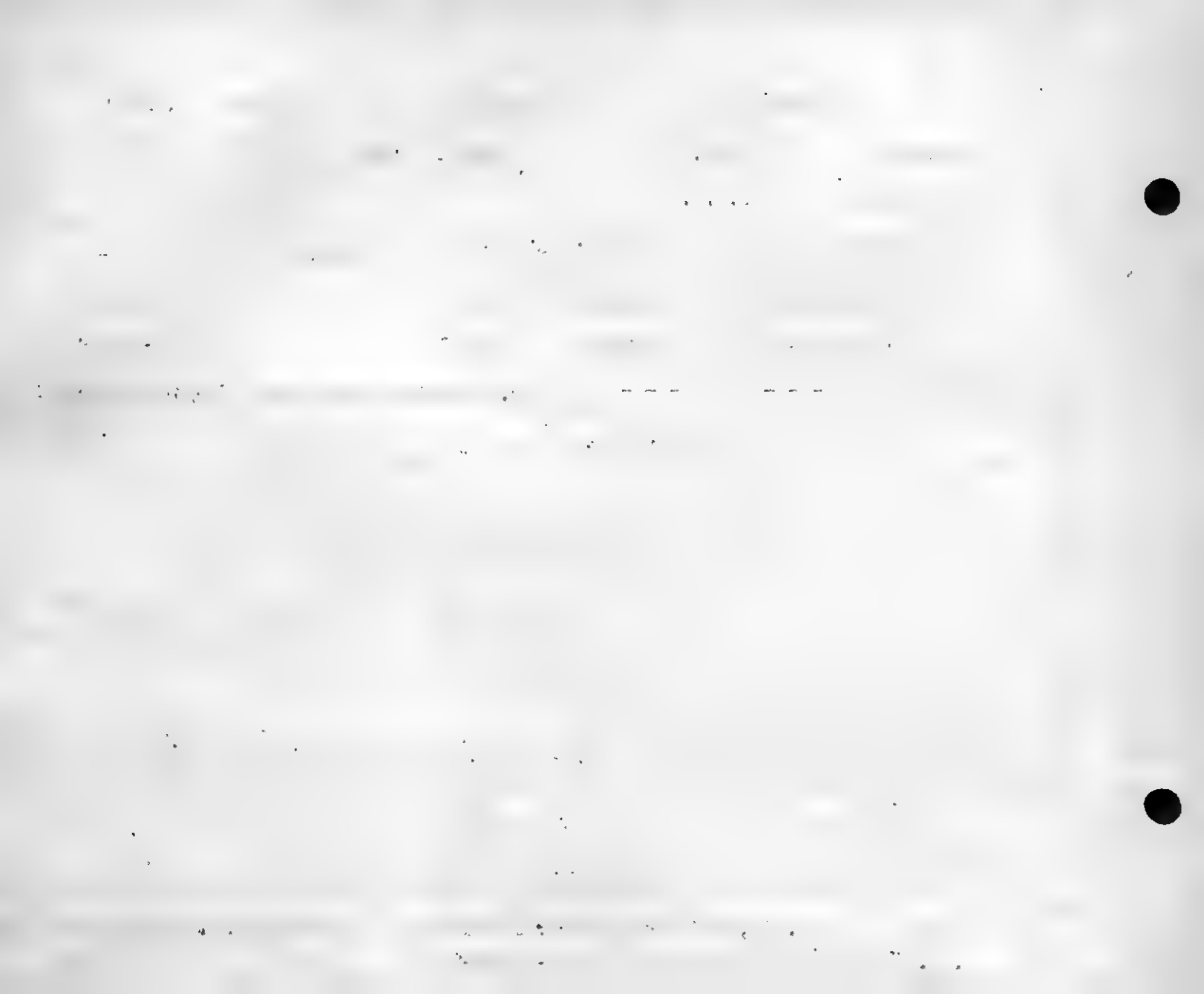
00421			00420			
1. DECEASED NAME (Type or print) First Middle Last <b>THOMAS Joseph HUGHES</b>			2a. DATE OF DEATH Month Day Year <b>1 24 69</b>			2b. HOUR <b>3 P. M.</b>
3 SEX <b>MALE</b>	4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>10-22-88</b>		6. AGE (In years last birthday) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>baltimore</b> Md.
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT BALT. MED. CEN.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Chief Clerk of Court</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ret. Balt. Co.</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER <b>37 Lambourne Road</b>						
14. FATHER'S NAME First Middle Last <b>Michael Hughes</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Hanley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>None</b>		16b. SOCIAL SECURITY NO. <b>215-03-0089A</b>		17. INFORMANT Address <b>Family records</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY FAILURE</b> <b>5320</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DUODENAL ULCER-BLEEDING</b> APP. 1 MO. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>VENTRICULAR ANEURYSM</b>						
19a. DATE OF OPERATION <b>1-15-69</b> <b>1-17-69</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TRACHEOTOMY</b> <b>PYLORIC OBSTRUCTION</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>12-31, 1968</b> , to <b>1-24-, 1969</b> , that (I) (we) last saw the deceased alive on <b>1-24, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Sabanayagam</b>		22c. DATE SIGNED <b>1-24-69</b>		22d. PHYSICIAN'S NAME (Type) <b>DR. P. SABANAYAGAM, M.D.</b>		
22e. ADDRESS <b>6701 N. CHARLES ST</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 28, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Jim Burns, Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 30 1969</b>		25b. REGISTRAR'S SIGNATURE <b>John J. J...</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Carmelina			IMBRAGUGLIO			JANUARY 27, 1969		M	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. UNDER 1 YEAR	
Female		Cauc.		May 18, 1895		73 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Italy		U.S.A.				Baltimore		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		7104 Marston Road		Homemaker		---			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admision) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Baltimore				7104 Marston Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Salvatore			Peraro			Maria Marianna			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			---			Mr. Antonino Imbraguglio 7104 Marston Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of Stomach								1 yr	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1967, 19, to 1/28, 1969, that (I) (we) last saw the deceased alive on 1/28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edward S. Kallins M.D.				22c. DATE SIGNED 1/28/69				22d. PHYSICIAN'S NAME (Type) EDWARD S. KALLINS, M.D.	
22e. ADDRESS 6000 PARK HTS AV									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 31, 1969		New Cathedral Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR J. E. Lowell Lemmon				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
4611 Park Heights Avenue				FEB 3 1969		K. Chomley Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 414  
45M 1/14/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Day Year		
MAMIE			A.		IH HOFF				JAN 8 1969		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (n years last birthday)		7 UNDER 1 YEAR		8 UNDER 24 HRS	
FEMALE		WHITE		JUNE 22/1879		89		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
BALTO... MO.		U.S.A.				BALTIMORE					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
CATONSVILLE		PARADISE NURSING HOME		FOREMAN (ret.)		PRINTING CO					
13a USUAL RESIDENCE (Where deceased lived, if institution)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIM 15?		13e STREET AND NUMBER			
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		OLD FREDERICK ROAD			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
WILLIAM HOOD			MARY HICKMAN								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Address							
NO		213 05 6866		MRS. CATHERINE MARTIN (niece) Glen Burnie							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, viral</u>										2	
480X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Congestive Heart Failure, Anterior Septal Heart Disease</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <u>1-7</u> , 19 <u>69</u> , to <u>1-8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-7</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE										22c DATE SIGNED	
<u>D. Sorongon</u>										1/8/69	
22d PHYSICIAN'S NAME (Type)				22e ADDRESS							
DOMINGO C. SORONGON				3915 HOLLINS FERRY RD. BALTO. MD. 21227							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
BURIAL		JANUARY 11/69		HOLY CROSS CEMETERY		BALTIMORE, MARYLAND					
24 FUNERAL DIRECTOR		SINGLETON FUNERAL HOME		25a DATE OF REGISTRATION		25b. ADDRESS OF SIGNATURE					
R. V. Singleton		GLEN BURNIE, MARYLAND		JAN 13 1969							



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR M
		FIELDER		D.		IRELAND		1 18 69			
3. SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS		7. UNDER 24 HRS. HOURS		7. UNDER 24 HRS. MIN.
MALE	WHITE		10-11-91		77 YRS.						
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
MARYLAND		USA				BALTIMORE					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
EDMONDSON HGHTS.		1132 WEDGEWOOD RD.		RETIRED FOREMAN		B & O					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
MD.		BALTO.		EDMONDSON				1132 WEDGEWOOD RD.			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
HENRY C. IRELAND				ELLA C. DORSEY							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT Address							
NO		705056153		ELIAMAE HOOVER 1132 WEDGEWOOD RD. 21229							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>185X</u> <u>HEPATIC ENCEPHALOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEPATIC STAIN</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HEPATIC ENCEPHALOPATHY</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/11/69</u> , to <u>1/18/69</u> , that (I) (we) last saw the deceased alive on <u>1/18/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John H. Shaw</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>1/20/69</u>					
22d. PHYSICIAN'S NAME (Type) DR. JOHN H. SHAW				22e. ADDRESS 5800 EDMONDSON AVE. BALTO., MD.							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		1-22-69		LOUDON PARK CEM.		BALTO., MD.					
24 FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HOWARD H. HUBBARD				4107 WILKENS AVE. 21229		JAN 21 1969		<u>Charles Judge</u>			



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VR 1-1-68  
304 REV 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First William Middle (NMN) Last Ireland			2a. DATE OF DEATH 1 Month Day 7 Year 69			2b. HOUR 12:03 M			
3. SEX Male			4. RACE White			5. DATE OF BIRTH Oct. 12, 1898			6. AGE (In years last birthday) XX 70 YRS		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Nebraska			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore, Maryland Md.			
10. CITY OR TOWN OF DEATH Baltimore Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Manager			12b. KIND OF BUSINESS OR INDUSTRY Dept. Store			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY, Y.N. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 603 Fairway Drive 21204	
14 FATHER'S NAME First Middle Last James D. Ireland			15. MOTHER'S MAIDEN NAME First Middle Last Hannah Mc Pherson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1			16b. SOCIAL SECURITY NO. 167-01-5306			17 INFORMANT Address Mrs. Regina Ireland Same as # 13 E						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Massive Myocardial Infarction</i> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (1) (This hospital) attended the deceased from 1/24, 1964, to 1/6, 1969, that (1) we) last saw the deceased alive on 1/5, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE W. M. Smith M.D.			22c. DATE SIGNED 1/7/69			22d. PHYSICIAN'S NAME (Type) W. M. Smith			22e. ADDRESS 6305 THE ALAMEDA			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 1-10-69			23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gar.			23d. LOCATION (City or Town) (County) (State) Cockeysville Md.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc.			25a. REC'D BY REGISTRAR JAN 3 1969			25b. REGISTRAR'S SIGNATURE Charles Judge						



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00425

00425

1. DECEASED NAME (Type or print) <b>J. OVIDE ISABELLE</b>			2a. DATE OF DEATH Month <b>1</b> - Day <b>17</b> - Year <b>69</b>		2b. HOUR <b>5:45</b> PM
3 SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>9-20-1893</b>		6 AGE (In years last birthday) <b>75</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>BALTIMORE</b> Md		
10. CITY OR TOWN OF DEATH <b>TOWSON, MD.</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired School teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>1516 Windemere Ave., 21218</b>	
14. FATHER'S NAME First <b>Arthur</b> Middle <b>Isabelle</b> Last <b>Magnant</b>		15. MOTHER'S MAIDEN NAME First <b>Almeria</b> Middle <b>Magnant</b> Last <b>Magnant</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>Yes</b> (If yes give war or dates of service) <b>WW I</b>		16b. SOCIAL SECURITY NO <b>219-22-4497</b>		17. INFORMANT Address <b>(Same)</b> <b>Mrs. Angelina Isabelle</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>411</b> DUE TO, OR AS A CONSEQUENCE OF <b>acute myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF (c) last					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1-14</b> , 19 <b>69</b> , to <b>1-17</b> , 19 <b>69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1-17</b> , 19 <b>69</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.					
22b. SIGNATURE <b>Ines Cilliani, M.D.</b>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-18-1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>Ines Cilliani, M.D.</b>		22e. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL, (specify) <b>Burial</b>	23b. DATE <b>1/22/69.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery #2</b>		23d. LOCATION (City or Town) (County) (State) <b>Boston, Mass.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JAN 20 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>EDITH</b>		First	Middle	Lost	2a. DATE OF DEATH January <b>31</b> , 19 <b>69</b>		2b. HOUR <b>10:55</b>
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>8-13-1888</b>		6 AGE (in years last birthday) <b>80</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased admission) - STATE <b>Maryland</b>		13b. COUNTY <b>Severna Park</b>		13c. CITY OR TOWN <b>Severna Park</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>Box 207, Inverness Road</b>		14. FATHER'S NAME First Middle Lost		15. MOTHER'S MAIDEN NAME First Middle Lost		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO <b>---</b>		17. INFORMANT <b>Mr. William Jacob, 401 Hilton Ave., 21228</b>		17. ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>5/5 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Aortic insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <b>Uremia</b>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm, street factory, office building etc.)		21f. LOCATION Street or R.F.D. No City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 28</b> , 19 <b>69</b> , to <b>Jan. 31</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>Jan. 31</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE <b>Lorna G. Gaudiel, M.D.</b>		22c. DATE SIGNED <b>Jan. 31, 1969</b>		22d. PHYSICIAN'S NAME (Type) <b>Lorna G. Gaudiel, M.D.</b>		22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/4/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Witzke, 4101 Edmondson Ave., 21229</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 5 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15  
304 REV 1-60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1043

00427

1. DECEASED NAME (Type or print) <b>Nora</b>		First <b>W.</b>	Middle	Last <b>James</b>	2a. DATE OF DEATH <b>1</b> Month <b>3</b> Day <b>1969</b>		2b. HOUR <b>M</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>9/23/1882</b>		6. AGE (In years last birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b>	OAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	MIN. <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b>		Md.			
10. CITY OR TOWN OF DEATH <b>MILLERSVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ROLLWOOD MANOR NURSING HOME</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>MD</b>		13b. COUNTY <b>TALBOT</b>		13c. CITY OR TOWN <b>VILGHMAN</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER			
14. FATHER'S NAME First <b>WILLIAM J.</b> Middle <b>LOWERY</b> Last				15. MOTHER'S MAIDEN NAME First <b>ALICE</b> Middle <b>COVINGTON</b> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>UNKN</b>		17. INFORMANT <b>MRS EMILY HUGH, HALETHORPE, MD.</b>		Address					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>none</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 15, 1962</b> , to <b>Jan. 5, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan. 1, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <b>R. M. McLaughlin, M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/9/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>R. M. McLaughlin</b>				22e. ADDRESS <b>3708 Mountain Rd. Pasadena, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1/6/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METHODIST</b>		23d. LOCATION (City or Town) (County) (State) <b>TILGHMAN, MD.</b>					
24. FUNERAL DIRECTOR <b>MAURICE E. NENNA &amp; SON, EASTON, MD</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 14 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. Judge</b>			

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

00428

## 1. NAME OF DECEASED

(Type or Print)

SAMUEL JEFF

## 2. DATE AND HOUR OF DEATH

JAN 29, 1969

6:15 A.M.

## 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

BALTIMORE COUNTY

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

6910 Brookmill Rd

## 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

## E. STREET AND NUMBER

6910 Brookmill Road

## 5. SEX

M

## 6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## 8. DATE OF BIRTH

Sept 26, 1896

## 9. AGE (In years last birthday)

72

## If Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Credit Manager

## 10B. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

Maryland

## 12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME

Michael

## 14. MOTHER'S MAIDEN NAME

Ida

## 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Mrs Bertha Jeff

## ADDRESS

Same

## 18.

## CAUSE OF DEATH

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Ca of Stomach

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF

## APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

60 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

(B) DUE TO, OR AS A CONSEQUENCE OF

(C) DUE TO, OR AS A CONSEQUENCE OF

## OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

22. I certify that (I) (this hospital) attended the deceased from June 1966 to Jan 29, 1969, that (I) (we) last saw the deceased alive on January 27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

## 23A. SIGNATURE

Joseph C. Matchar MD

Attending Phys. ☒Med Director ☐Staff Phys. ☐

## 23B. DATE SIGNED

1/29/69

## 23C. PHYSICIAN'S NAME (Print)

Joseph C. Matchar MD

## 23D. ADDRESS

6821 REISTERSTOWN Rd, BALTIMORE

## 24A. BURIAL OR CREMATION, REMOVAL (Specify)

Burial

## 24B. DATE

1/30/69

## 24C. NAME OF CEMETERY OR CREMATORY

Arlington

## 24D. LOCATION

Baltimore

## (City, town, or county)

## (State)

Maryland

VR 15-45M

## 25A. DATE RECEIVED BY HEALTH DEPT

FEB - 4 1969

## 25B. NAME OF RECEIVING OFFICER

Charles J. Jorgensen

## 25C. FUNERAL DIRECTOR

Sylvan S. Jorgensen &amp; Son, Inc. 9610 Reisterstown Rd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and place them in the envelope provided. The envelope should be placed in the envelope provided and in any event within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

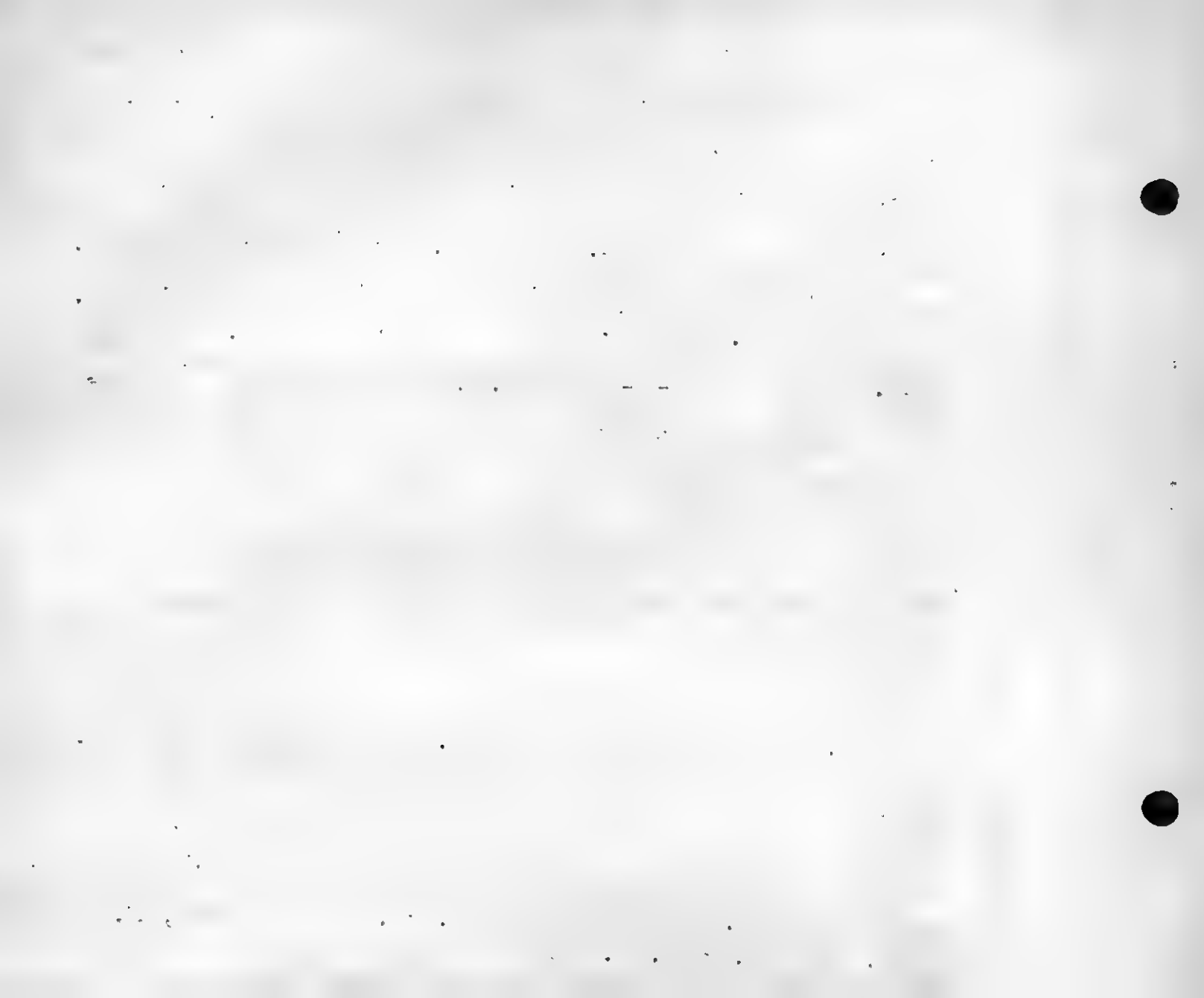
VR 4-13-64  
301-17-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00429

1. DECEASED NAME (Type or print) <b>Alfred</b>		First <b>W</b>		Middle <b>Jessnitzer</b>		Last		2c. DATE OF DEATH Month <b>January</b> Day <b>3</b> Year <b>1969</b>			2b. HOUR <b>M</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>7/23/1900</b>		6. AGE (in years last birthday) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b>		IF UNDER 24 HRS HOURS <b>00</b> MIN. <b>00</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md						
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during last 12 months) <b>Retired Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Meat Co.</b>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>7300 Old Harford Rd.</b>				
14. FATHER'S NAME First <b>Paul</b> Middle <b>H. Jessnitzer</b> Last		15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>K.</b> Last <b>Heansler</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>unk.</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>213-03-9301 A</b>		17. INFORMANT <b>Mrs. M. Louise Jessnitzer</b>				Address <b>(Same)</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial infarct</b> <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>A.S.C.V.D. (Pre infarct)</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>11-7-68</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11-7-68</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>diabetes (uncontrolled)</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>7/23/68</b> , 19 <b>68</b> , to <b>1/3</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>1/27/69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>John A. Mitchell, M.D.</b>		DEGREE <b>MD</b>		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/3/69</b>						
22d. PHYSICIAN'S NAME (Type) <b>JOHN A MITCHELL, MD.</b>		22e. ADDRESS <b>ST. JOSEPH HOSP. BALTO MD</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/6/69.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>						
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>PAN 6</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>		1969				



00434

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

1 DECEASED NAME (Type or print) <b>CHARLES</b>		First Middle Last <b>JOHNSON</b>		2a. DATE OF DEATH Month <b>1</b> Day <b>2</b> Year <b>69</b>		2b. HOUR <b>8:40AM</b>	
3 SEX <b>MALE</b>		4 RACE <b>NEGRO</b>		5 DATE OF BIRTH <b>4/15/14</b>		6 AGE (In years) <b>54</b> (last birthday) YRS MONTHS DAYS HOUR MIN	
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>BALTIMORE COUNTY</b>	
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>VET. AFF. HOSPITAL</b>		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <b>MANAGER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>HOTEL</b>	
13a USUAL RESIDENCE (Where deceased abode, if institution Residence before admission) STATE <b>MARYLAND</b>		13b COUNTY <b>BALTIMORE</b>		13c CITY OR TOWN <b>BALTIMORE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>1903 McCulloh Street</b>							
14. FATHER'S NAME First Middle Last <b>Fremuntius J. Johnson</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>Annie Jackson</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16b SOCIAL SECURITY NO <b>WW II</b>		17 INFORMANT Address <b>CLIN. RECORDS, VA HOSP. FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>48.5X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>PULMONARY EDEMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CIRRHOSIS OF LIVER</b>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory, office, etc.)		21f LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/9/68</b> , 19__, to <b>1/2/69</b> , 19__, that (I) (we) last saw the deceased alive on <b>1/2/69</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <b>Madhav Barhanpurkar</b> DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/2/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>MADHAV D. BARHANPURKAR, M. D.</b>				22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE <b>1-6-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24 FUNERAL DIRECTOR		ADDRESS <b>Joseph Locks Funeral Home</b>		25a REC'D BY REGISTRAR <b>Homan 6</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1301 1302



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (10)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  00433 </div> <div> <b>CERTIFICATE OF DEATH</b>  00431 </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN ID <u>17 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Hospital</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>614 S. Patterson Park Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>CLAYTON</u> Middle <u>VERNON</u> Last <u>JOHNSON</u> <b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>4</u> Year <u>1969</u> <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1-11-23</u> <b>9. AGE</b> (In years last birthday) <u>45</u> yrs. <b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HRS.</b> Hours _____ Min. _____						<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) _____ <b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____ <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>md. U.S.A.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>William Johnson</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine Neels</u>						<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> <u>Rosewood Medical Record</u> Address <u>Owings Mills Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 406X DUE TO (b) <u>Encephalopathy of unknown etiology</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>with diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town) (County) (State)</b> _____											
<b>21. I certify that (if this hospital) attended the deceased from <u>7-26-1967</u>, to <u>1-4-1969</u>, that (if we) last saw the deceased alive on <u>1-4-1969</u>, and that death occurred at <u>8:22 AM</u>, from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <u>Lucricia F. Jovan</u> M.O. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>22b. DATE SIGNED</b> <u>1-5-69</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. Lucricia F. Jovan</u> <b>22d. ADDRESS</b> <u>Rosewood State Hospital.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>1-8-69</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MEADOWRIDGE MEM. PK.</u> <b>23d. LOCATION (City, town or county) (State)</b> <u>ELKRIDGE MD.</u> <b>24. FUNERAL DIRECTOR</b> <u>Raymond L. Kaczorowski</u> ADDRESS <u>2525 Fleet St.</u> <b>25a. REC'D BY REGISTRAR</b> <u>Jan 9 1969</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

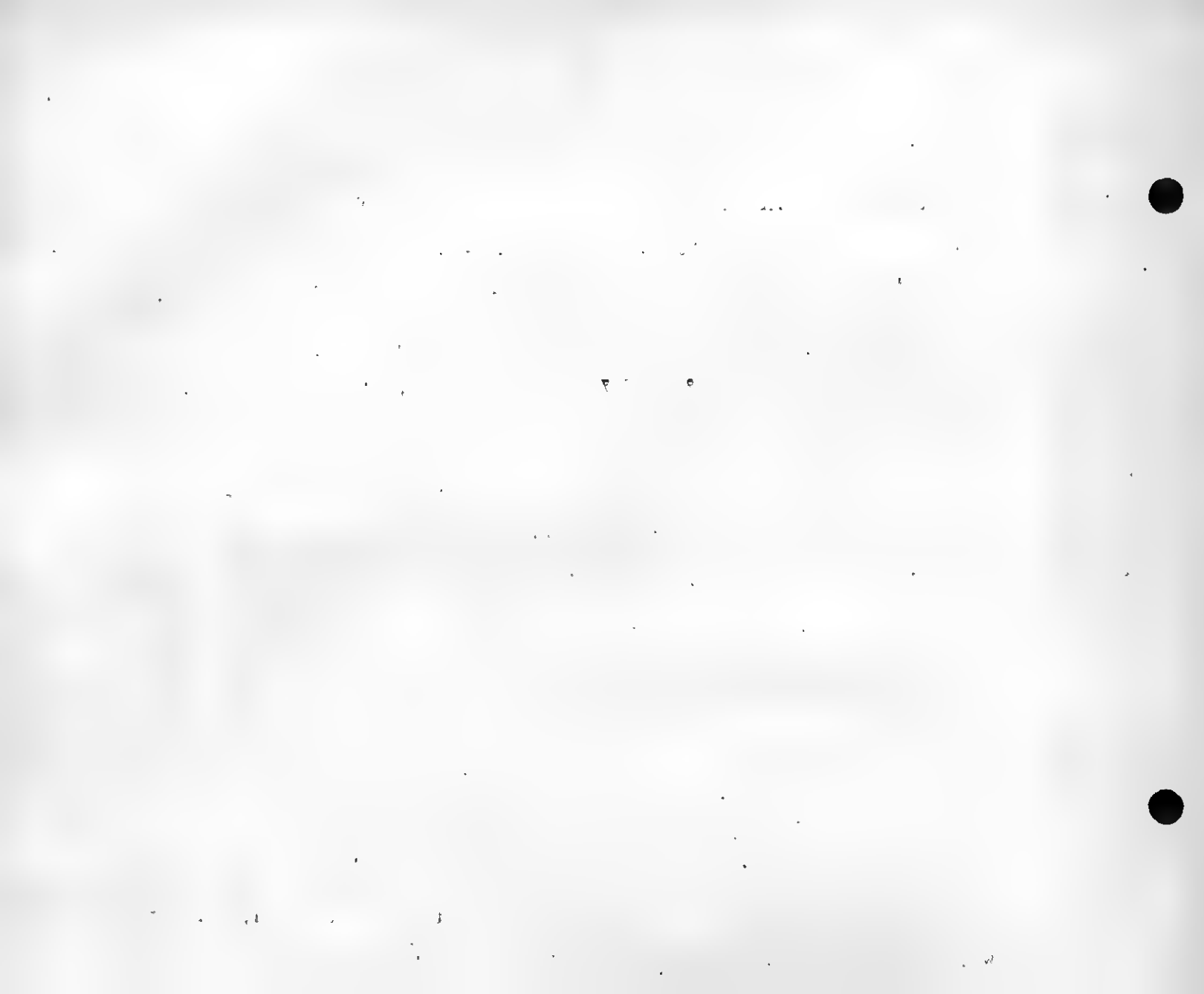
10430

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00432

# CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b HOUR	
LYDA				JOLLY	1 Month 26 Day 69 Year		2:15 a.m.	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		Cau.		July 4, 1890		78 YRS.		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		U.S.A.				Baltimore Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson		Greater Balto. Med. Center		Sales		Dept. St.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		510 Glen Allan Drive
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
James W. Jolly					Julia M. Price			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
		212-07-7507		Pickersgill, 615 Chestnut Ave. Towson, Md.		21204		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal shutdown</u>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								
(b) <u>Nephrosclerosis and status post resection of</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c) <u>colon for adenocarcinoma</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
<u>Hypertensive cardiovascular disease</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
1/20/69		Anterior resection of colon		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1/8</u> , 1969, to <u>1/26</u> , 1969, that (I) (we) last saw the deceased alive on <u>1/26</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED		
John E. Adams						1/26/69		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
John E. Adams, M.D.		6701 N. Charles Street						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		1-29-1969		Lorraine Park Cemetery		Woodlawn, Maryland		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wm. Cook-Brooks Towson,		1050 York Road Towson, Maryland		JAN 30 1969		[Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00433									
Item 1 Filed 09/2/24/69 kk									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
CHARLES			H. Henry JONES			Month 1 Day 17 Year 69		4:30 AM	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS	
MALE		CAUC		August 20, 1912		56 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				BALTIMORE			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON, MARYLAND		GRK. BALTO. MED. CENTR		Service, Burners		Oil Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Baltimore				9107 Hines Road, 21234	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Charles Henry Jones, Sr.			Sarah E. Hale						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		215-10-6307		Gertrude E. Jones, Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST									5 MIN.
2124 DUE TO, OR AS A CONSEQUENCE OF PLEURAL MESOTHELIOMA WITH METASTASIS									1 YR.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1-08, 1969, to 1-17, 1969, that (I) (we) last saw the deceased alive on 1-17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
B.R. Friedlander		MD				1-17-69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
B.R. FRIEDLANDER		6701 NORTH CHARLES ST.							
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		Jan. 20, '69		Parkwood Cemetery		Parkville Maryland			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. Cook-Brooks Towson,		1050 York Road		DATE 1-20-1969		Charles Judge			
		Towson, Md. 21204							



## CERTIFICATE OF DEATH

00434

1. DECEASED-NAME (Type or print) <b>MOSES</b>			First	Middle	Last	2a. DATE OF DEATH Month <b>1</b> Day <b>5</b> Year <b>1969</b>			2b. HOUR <b>8:30 P.M.</b>	
3 SEX <b>Male</b>		4 RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>3-10-02</b>		6. AGE (in years last birthday) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>1</b>		IF UNDER 24 HRS HOURS <b>1</b> MIN <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County, Md.</b>				
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Mt. Wilson State Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>219 Suder Road</b>	
14. FATHER'S NAME First <b>James</b> Middle <b>Jones</b> Last <b>Jones</b>			15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Thomas</b> Last <b>Thomas</b>							
16a. WAS DECEASED Yes, no (known) <b>No</b>			16b. SOCIAL SECURITY NO <b>216-28-8049</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY insufficiency due to the</b> DUE TO, OR AS A CONSEQUENCE OF <b>diabetes mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>diabetes mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CHRONIC RENAL insufficiency</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>12/6, 1968</b> , to <b>1/5, 1969</b> , that (I) (we) last saw the deceased alive on <b>1/5, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>W. Newcomer</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/5/69</b>				
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>				22e. ADDRESS <b>Mount Wilson, Maryland</b>						
23a. BURIAL CREMATION (Type or print) <b>Burial</b>		23b. DATE <b>1/9/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Star Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Co. Maryland</b>			
24. FUNERAL DIRECTOR <b>HERBERT NUTTER 3035 W. NORTH</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 8 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)



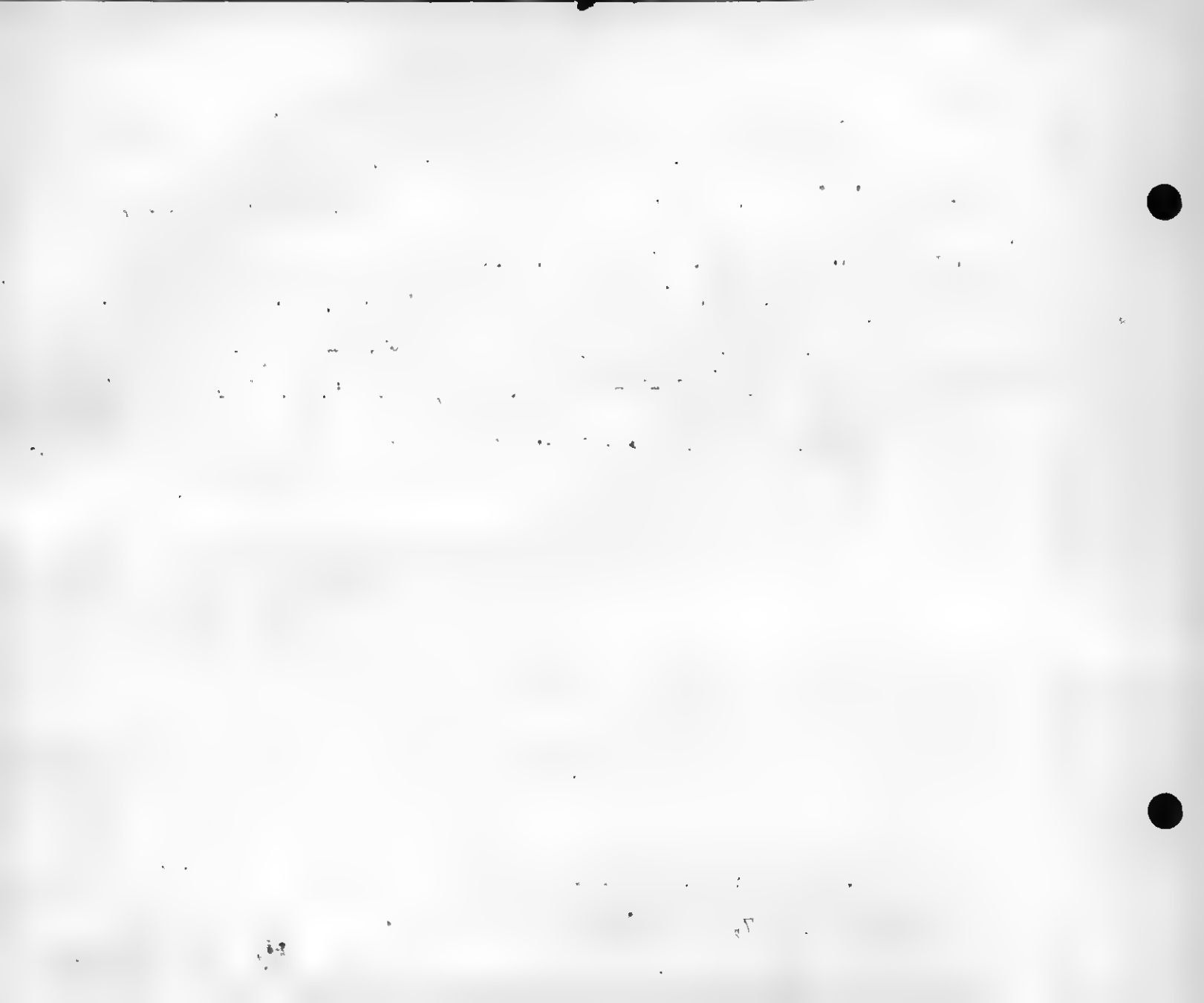
## CERTIFICATE OF DEATH

00435

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR	
Robert				JONES	Jan 2 1969			8:10 PM	
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	Negro	5-14-96			72 YRS		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Northumberland		U. S. A.				Baltimore County, Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Mount Wilson		Mt. Wilson St. Hosp.							
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b CITY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.		Balto. City		Baltimore				1715 W. Lexington St.	
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Robert				Jones	Jane Adams				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address			
yes		W. W. 2		215-16-9868		Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA @ LUNG</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CARDIAC HYPERTROPHY @ VENT; PULM. EMPHYSEMA</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-18, 1968, to 1-2, 1969, that (I) (we) last saw the deceased alive on 1-2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
William Newcomer								1-3-69	
22d PHYSICIAN'S NAME (Type)		22e. ADDRESS			22c. DATE SIGNED				
William Newcomer, M.D.		Mount Wilson, Maryland							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Jan 3, 1969		Baltimore National Cem.		Baltimore Maryland			
24 FUNERAL DIRECTOR		ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Herbert E. Tuller		3035 W. North Ave.			DATE JAN 8 1969		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

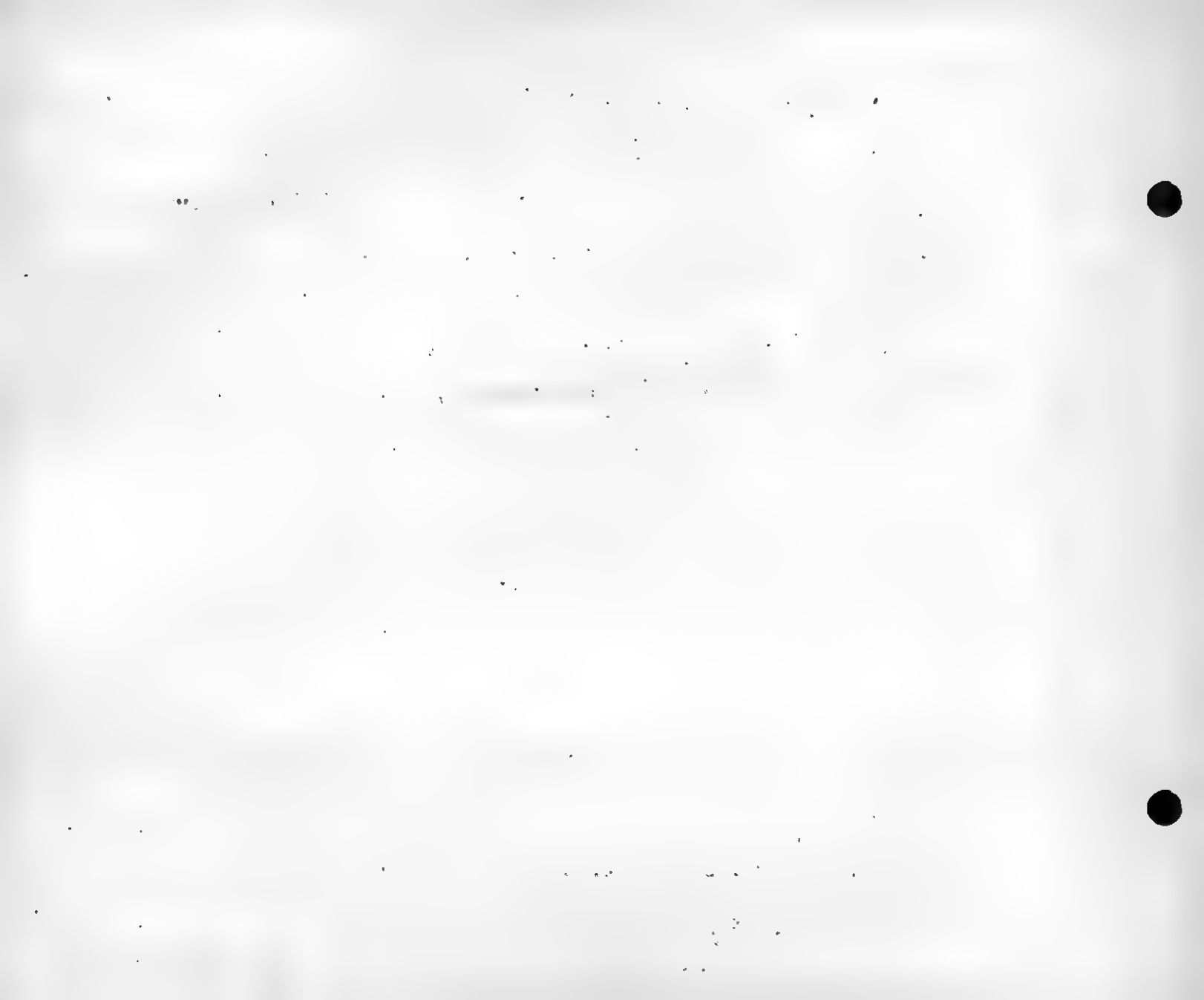
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) <b>WILBUR ALONSO JOSLIN</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>2</b> Year <b>69</b>		2b. HOUR <b>10:50 AM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>5.10.1881</b>		6. AGE (In years last birthday) <b>87</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Balto, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore County, Md.</b>	
10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson St. Hosp.</b>		12a. US&A. OCCUPATION (Kind of work done during most of working life, even if retired) <b>clerk</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto</b>	13c. CITY OR TOWN <b>Balto</b>	13d. INSIDE CITY LIM. 15? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>704 Old Home Rd.</b>
14. FATHER'S NAME First <b>GEORGE</b> Middle <b>JOSLIN</b> Last <b>KATE</b>		15. MOTHER'S MAIDEN NAME First <b>KATE</b> Middle <b>RINDHARD</b> Last <b>RINDHARD</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>2-2-10-3196A</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arteriosclerotic heart disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>4.7</b> , 19 <b>67</b> , to <b>1.2</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>1.2</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W. Newcomer</b>				22c. DATE SIGNED <b>1.2.1969.</b>	
22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>				22e. ADDRESS <b>Mount Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-6-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Landon</b>	
23d. LOCATION (City or Town) (County) (State) <b>Baltimore Bal. Md.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook Brooks Towson Md.</b>			
25a. REC'D BY REGISTRAR DATE <b>JAN 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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VR A15  
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First <b>MARIE</b>		Middle <b>A.</b>		Last <b>KARWACKI</b>		2a. DATE OF DEATH Month Day Year <b>Jan. 14, 1969</b>			2b. HOUR <b>M</b>
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>9/22/1906</b>			6. AGE (In years last birthday) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>62</b>		IF UNDER 24 HRS. HOURS MIN. <b>62</b>
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>			Md.		
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Dulaney Towson</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Ins. Agent</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>self-employed</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>500 W. University Pkwy. 21210</b>			
14. FATHER'S NAME First Middle Last <b>Andrew Budzynski</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Josephine Nowakowski</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>218-42-3727</b>		17. INFORMANT <b>5004 St. Albans Way</b>			21212 <b>Robert Karwacki, son.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTIFICIAL SELF-INDUCED RHEUMATIC HEART DISEASE</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>PULMONARY FIBROSIS</b>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 27, 1968</b> to <b>Jan. 14, 1969</b> , that (I) <b>viewed</b> saw the deceased alive on <b>January 14, 1969</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we) (did)</b> (did not) view the body after death.											
22b. SIGNATURE <b>T. C. Siwinski</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Jan. 16, 1969</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Thaddeus Siwinski</b>				22e. ADDRESS <b>21204 206 W. Pennsylvania Ave.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1/17/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>				
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>				ADDRESS <b>3331 Brehms Lane</b>		25a. REC'D BY REGISTRAR DATE <b>Jan. 20 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

VR A15 (4)  
30M REV 1/68

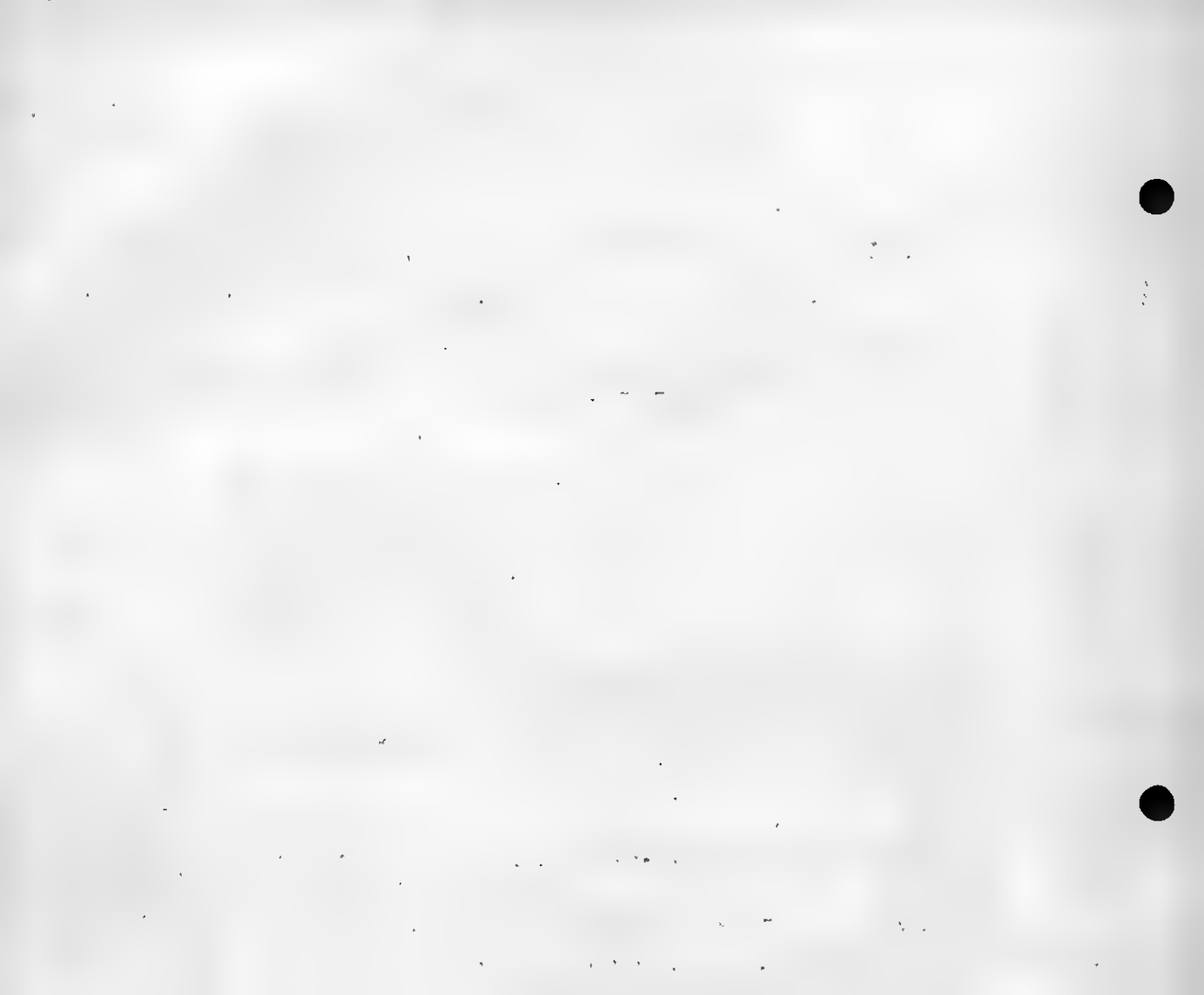
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

20442

00438

1 DECEASED NAME (Type or print) <b>Elizabeth M. Katenkamp</b>			2a DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>1969</b>			2b HOUR <b>11:45</b> a.m.	
3 SEX <b>female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH <b>Dec. 4, 1880</b>		6 AGE (In years last birthday) <b>88</b> YRS	
7a BIRTHPLACE (State or foreign country) <b>Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Baltimore</b>	
10 CITY OR TOWN OF DEATH <b>Catonsville</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRING GROVE STATE HOSP.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>housewife</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b COUNTY <b>Balto.</b>		13c CITY OR TOWN <b>Balto.</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>4721 Dartford Avenue</b>		14 FATHER'S NAME First <b>William</b> Middle <b>Huber</b> Last <b>Miller</b>		15 MOTHER'S MAIDEN NAME First <b>E. Huber</b> Middle <b></b> Last <b></b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO. <b>216-54-1036</b>		17 INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Decubitus ulcers</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 4, 1964</b> to <b>Jan. 16, 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan. 16, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Diomidis Pirovolidis</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-16-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Diomidis Pirovolidis, M.D.</b>		22e ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE <b>1-20-1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Woodlawn, Maryland</b>	
24 FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave.</b>		ADDRESS <b>21229</b>		25a RECD BY REGISTRAR <b>JAN 20 1969</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	



## CERTIFICATE OF DEATH

00442

10439

1. DECEASED NAME (Type or print) <b>Mary Kaufman</b>			2a. DATE OF DEATH <b>1/31/69</b> Month Day Year			2b. HOUR <b>p</b> M	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>1/28/78</b>		6. AGE (In years last birthday) <b>91</b> YRS.	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore</b>		Md		
10. CITY OR TOWN OF DEATH <b>Arbutus</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>909 Beechfield Ave</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Stenographer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>	13b. COUNTY <b>Balto</b>	13c. CITY OR TOWN <b>Arbutus</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>909 Beechfield Ave</b>			
14. FATHER'S NAME First Middle Last <b>Frederick Kaufman</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth Roth</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>212-03-1039</b>		17. INFORMANT Address <b>Mrs. Cecelia Hayden, 909 Beechfield Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY <b>11124</b> IMMEDIATE CAUSE (a) <b>ASCU D</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR <b>AM</b> Month Day Year P.M. <b>9</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>1-13, 1969</b> to <b>1-31, 1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>1-31, 1969</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Earl Pass</b>			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>2-1-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dr. Pass</b>			22e. ADDRESS <b>4001 Wilkens Ave. 21227</b>				
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>Burial</b>	23b. DATE <b>2/4/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Witzke, 4101 Edmondson Ave. 21229</b>			25a. REC'D BY REGISTRAR DATE <b>FEB 5 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print)		First <b>Mary</b>	Middle <b>Bridget</b>	Last <b>KEECH</b>	2a. DATE OF DEATH Month <b>1</b> Day <b>19</b> Year <b>1969</b>		2b. HOUR <b>12 55</b> AM
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>January 18, 1969</b>		6 AGE (In years last birthday) YRS	IF UNDER 1 YEAR MONTHS	DAYS	UNDER 24 HRS HOURS
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore,</b>		Md	
10 CITY OR TOWN OF DEATH <b>Towson</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>N/A</b>		12b KIND OF BUSINESS OR INDUSTRY <b>None</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>	13b COUNTY <b>Baltimore,</b>	13c CITY OR TOWN <b>Towson</b>	3d INSIDE CITY, MTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <b>8171 Pleasant Plains Rd.</b>			
14 FATHER'S NAME First <b>Thomas</b> Middle <b>O.</b> Last <b>Keech</b>		15 MOTHER'S MAIDEN NAME First <b>Rosemary</b> Middle <b>--</b> Last <b>Staley</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes give war or dates of service)		16b SOCIAL SECURITY NO <b>None</b>		17 INFORMANT Address <b>Balto. Md.</b> <b>Mr. Thomas O. Keech 8171 Pleasant Plains Rd.</b>			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Erythroblastosis fetalis</b> <b>1740</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pulmonary atelectasis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1/18/</b> <b>19 69</b> , to <b>1/19/</b> <b>19 69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1/19/</b> <b>19 69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>ICilliani</b>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/19/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Ines Cilliani, M.D.</b>		22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>					
23a. BURIAL CREMATION, <b>BURIAL</b> (Specify)	23b. DATE <b>1/22/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Burial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany Md.</b>			
24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Maryland</b>				25a. REC'D BY REG. STRAR DATE <b>JAN 27 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		2b. HOUR
Michael		G.	Kerzog	Month Day Year January 16 1969		28 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years)	7. UNDER 1 YEAR	8. IF UNDER 24 HRS	9. DATE PRONOUNCED DEAD	2d. HOUR
M	W	6-23-98	70 YRS	MONTHS	DAYS	Month Day Year January 16 1969	28 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
PENNSYLVANIA		U.S.A.		Baltimore		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTO MARYLAND		St. Joseph's Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		STANDARD OIL	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD.		BALTO		BALTO		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET AND NUMBER		13f. STREET AND NUMBER	
UNKNOWN		UNKNOWN		9110 DECORAH AVE		9110 DECORAH AVE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS	
		244-04390		JOSEPH KOKOSZKA		1638 GRAYVIEW AVE	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).)		19. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> Sudden		DUE TO, OR AS A CONSEQUENCE OF		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2+ yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Cerebral Insufficiency</u>		DUE TO, OR AS A CONSEQUENCE OF			
(c)							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. DATE SIGNED		22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22d. ADDRESS (Street, city, town, or county)	
ACTUAL SIGNATURE		CHARLES O'DONNELL M.D.		22e. DATE SIGNED		1/16/69	
EXAMINER'S NAME (Type)		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
		BURIAL		1-20-69		ST. STANISLAUS CEM. DUNDRAK MD.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE	
JOHN M. WEBER & SONS INC. 401 S. CHESTER		JAN 20 1969		Charles Judge		JAN 20 1969	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2. Should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>JOSEPH ALEXANDER KING</b>					2a. DATE OF DEATH <b>1</b> Month <b>21</b> Day <b>69</b> Year		2b. HOUR P <b>5:40</b> M		
3 SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>1-5-06</b>		6 AGE (In years lost birthday) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md			
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREAT BALT MED CENT</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Chief Estate Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>105 Overbrook Road</b>	
14. FATHER'S NAME First Middle Lost <b>Hugh King</b>				15. MOTHER'S MAIDEN NAME First Middle Lost <b>Elizabeth R. Becker</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown		16b. SOCIAL SECURITY NO <b>219-30-5420</b>		17. INFORMANT Address <b>Mrs. Amelia C. King-105 Overbrook Rd. 21212</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTESTINAL OBSTRUCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CARCINOMA to liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of descending colon</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <b>12-23-</b> , 19 <b>69</b> <b>1/21</b> , 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>1-21</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>M. Mousavvi</i>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-21-69</b>		
22d. PHYSICIAN'S NAME (Type) <b>M. MOUSAVVI, M.D.</b>					22e. ADDRESS <b>6701 N CHARLES ST</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/25/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. City</b>			
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home-6500 York Rd. 21212</b>					25a. REGISTRY <b>JAN 27 1969</b>				



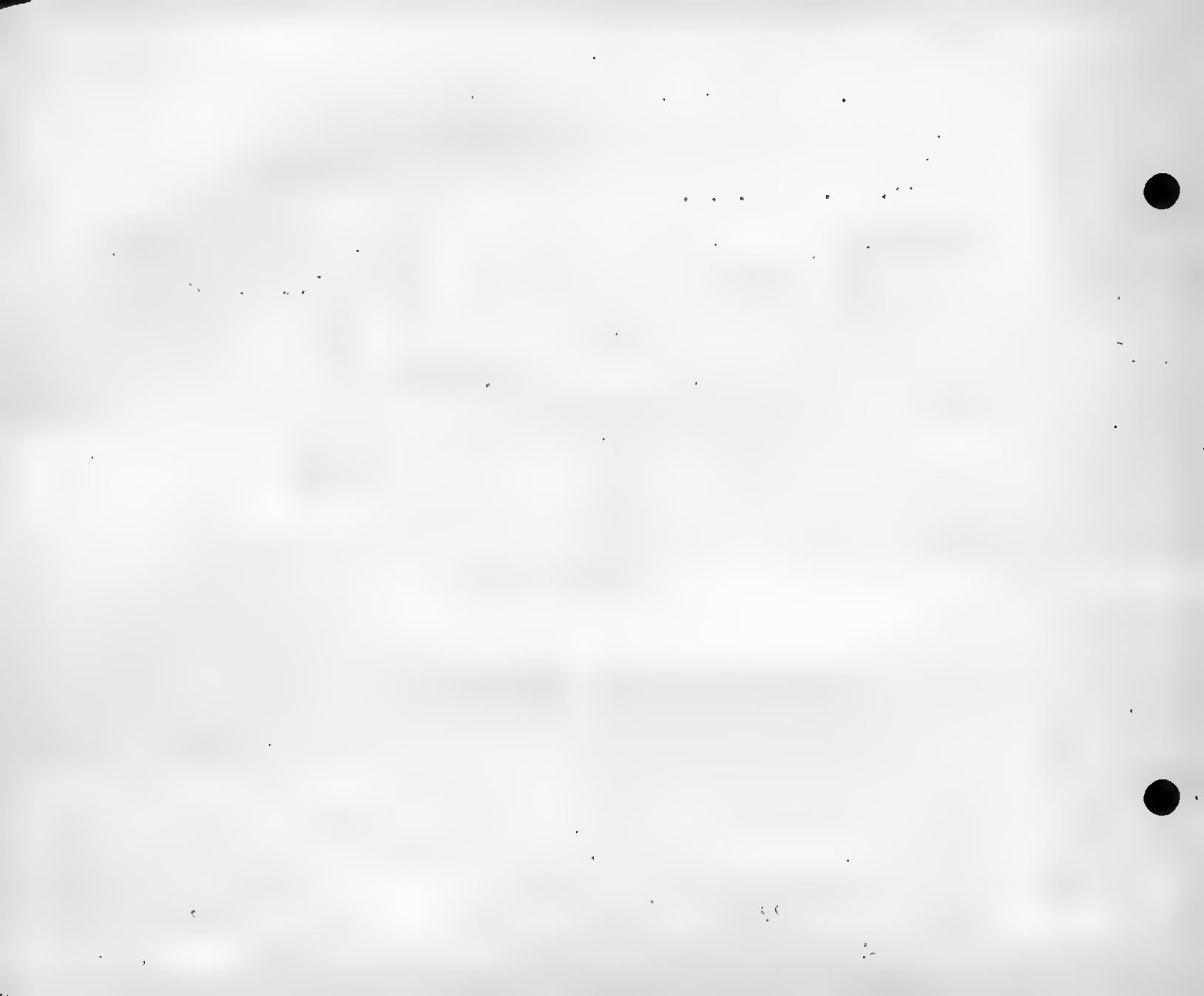
**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print) <b>JAMES HENRY HIRK</b>						2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month <b>JAN</b> Day <b>18</b> Year <b>1969</b>			2b HOUR <b>M</b>		
3 SEX <b>M</b>		4 RACE <b>W</b>		5 DATE OF BIRTH <b>8/13/76</b>		6 AGE (In years last birthday) <b>92</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		F UNDER 24 HRS HOURS <b></b> MIN <b></b>	
7a BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>BALTIMORE</b>		
10 CITY OR TOWN OF DEATH <b>Stoneleigh</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7006 BRISTOL RD.</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Inspector (Ret)</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>				13b COUNTY <b>BALTO</b>		13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>7006 Bristol Road 12</b>	
14 FATHER'S NAME First <b>Oliver</b> Middle <b></b> Last <b>Kirk</b>				15 MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Ann</b> Last <b></b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or UNKNOWN) <b>No</b>				16b SOCIAL SECURITY NO. <b>A-275-613</b>		17 INFORMANT <b>Mrs. Edward Ballard</b>				ADDRESS <b>7006 Bristol Road</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF DEATH Month, Day, Year HOUR A.M. <b>19</b> P.M. <b></b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>William A. Pillsbury</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED <b>1/18/69</b>			
EXAMINER'S NAME (Type) <b>William A. PILLSBURY</b>				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, City, Town, or County)							
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>1/22/69</b>		23c NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>			23d LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24 FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>						ADDRESS <b>6500 York Rd 12</b>		25a REC'D BY REGISTRAR <b>JAN 27 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First MARY			Middle VIRGINIA			Last KISNER		
2a. DATE KNOWN OF ESTI- DEATH MATED		<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year		2b. HOUR M		2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year		2d. HOUR A.M.		2e. HOUR P.M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH 5/1/15		6 AGE (In years last birthday) 54 YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country)		W. Va		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			
10. CITY OR TOWN OF DEATH Randallstown				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Laurel Hill Country Club				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) H.W.		12b. KIND OF BUSINESS OR INDUSTRY H.W.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER off Marriottsville Rd. off Powells Run Rd.	
14. FATHER'S NAME First Middle Last Lee Bonner						15. MOTHER'S MAIDEN NAME First Middle Last Catherine White					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO X		17. INFORMANT ADDRESS James Kisner Laurel Hill Country Club M.D.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carbon monoxide intoxication and thermal burns</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 5:30 1-11 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Found in burned trailer-home							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Laurel Hill Country Club		City or Town Randallstown		County Baltimore		State Md.	
22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED January 12, 1969					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/5/69		23c. NAME OF CEMETERY OR CREMATORY Donner Cem.		23d. LOCATION (City or Town) Dry Fork W. Va.		(County)		(State)	
24. FUNERAL DIRECTOR Loring Byers. 8728				ADDRESS Liberty Rd.		25a. REC'D BY REGISTRAR DATE JAN 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00445  
CERTIFICATE OF DEATH  
00445

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodlawn</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>3000 Rolling Road</i>		d. STREET ADDRESS <i>3000 Rolling Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Sadie</i> Middle <i>E.</i> Last <i>Kraft</i>		4. DATE OF DEATH Month <i>January</i> Day <i>20</i> Year <i>1969</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 19, 1886</i>
9. AGE (In years last birthday) <i>82</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Zink</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Family records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4124 Congestive Heart Failure</i> DUE TO (b) <i>A.S. C.V. Disease</i> DUE TO (c) <i>10 yr</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1-1</i> , 19 <i>67</i> , to <i>1-20</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1-17</i> , 19 <i>69</i> , and that death occurred at <i>7 P</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Herbert Mueller</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>C. HERBERT MUELLER JR</i>		22d. ADDRESS <i>PARKTON - MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan. 23, 1969</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Carroll's Chapel Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Reisterstown, Maryland</i>	
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>		25a. REG'D BY REGISTRAR <i>JAN 27 1969</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove transport papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

00450

00446

1. DECEASED-NAME (Type or print) First Middle Last <b>Emma Marie Krug</b>			2a. DATE OF DEATH Month Day Year <b>January 1, 1969</b>		2b. HOUR <b>1:40 PM</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>9/29/1901</b>		6. AGE (In years last birthday) <b>67</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Chesapeake Manor N.H.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Clerk</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Fleet-McGinley Inc.</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>12</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>1503 Pentridge Rd.</b>
14. FATHER'S NAME First Middle Last <b>Frank Rosendorm</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Emma A. Joynes</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-36-0879A</b>		17. INFORMANT Address <b>Mrs. Robert Bond, 106 Garden Ridge Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> <b>1829</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of uterus</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b> <b>1 year</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 1968</b> , to <b>Jan 1, 1969</b> , that (I) <del>lost</del> lost the deceased alive on <b>Jan 1, 1969</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did not) view the body after death.					
22b. SIGNATURE <b>J. Allan Spier</b>		DEGREE <b>MD.</b>		22c. DATE SIGNED <b>1/3/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. J. Allan Spier</b>		22e. ADDRESS <b>1501 Pentridge Road</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/4/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	
23d. LOCATION (City or Town) (County) (State) <b>Parkville, Balto. Co., Md.</b>					
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 6 1969</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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SECTION 111